

MIGRATION, MOBILITY AND HIV/AIDS:
A comparative study of rural and urban female sex
workers in northern Karnataka, India.

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A thesis submitted to the Kannada University, Hampi in
partial fulfillment of the Ph.D. degree in Social Work

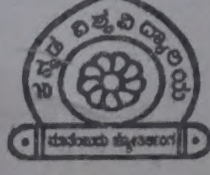


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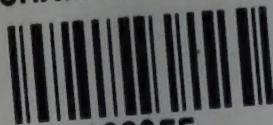
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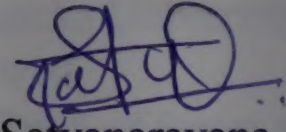
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RESEARCHER DECLARATION

I Mr. Satyanarayana hereby declare that, this research entitled **“Migration, Mobility and HIV/AIDS: a comparative study of rural and urban female sex workers in northern Karnataka, India”** is my original research work and conducted under the guidance of Prof. Vinod B. Annigeri and Prof. Vineeta B. Pai. This thesis is being submitted to the Department of Developmental Studies, Kannada University, Hampi, through Center for Multi-disciplinary Development Research (CMDR), Dharwad for the Ph.D. degree in Social Work. I hereby declare that this work either in part or in full has not been submitted for the award of degree or diploma in any University

Date: 19th August 2016

Place: Dharwad



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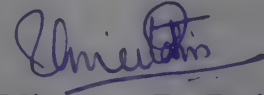
SUPERVISOR CERTIFICATE

This is to certify that this thesis entitled “**Migration, Mobility and HIV/AIDS: a comparative study of rural and urban female sex workers in northern Karnataka, India**” is a bonafide research work carried out by Mr. Satyanarayana, Research Fellow at CMDR-Dharwad under our supervision and guidance. This work is an original research work and this thesis is being submitted to the Department of Developmental Studies, Kannada University, Hampi, through CMDR, Dharwad for the Ph.D. degree in Social Work. We certify that this work either in part or in full has not been submitted for the award of degree or diploma in any University.



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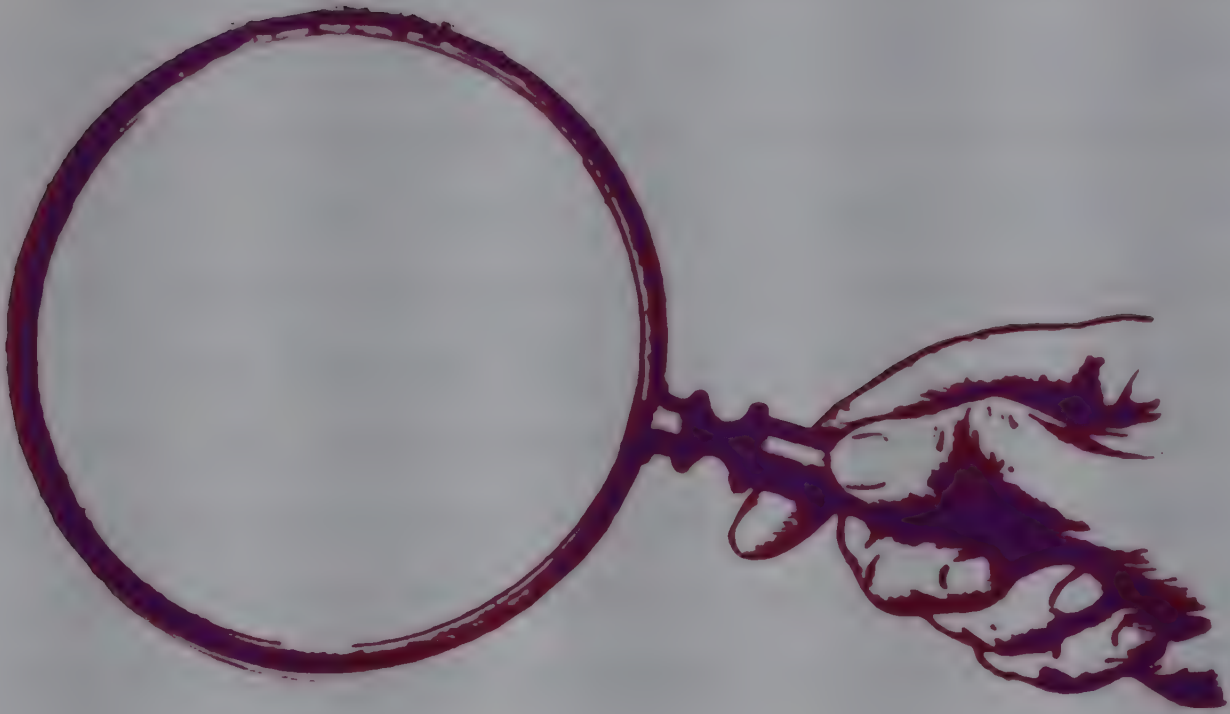
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ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral Therapy
BIRDS	Belgaum Integrated Rural Development Service Society
CAMS	Chaitanya AIDS tadegattuva Mahila Sangha
CBO	Community Based Organization
CDC	Centre for Disease Control
CHCs	Community Health Centers
CMDR	Center for Multi-disciplinary Development Research
FGD	Focused Group Discussion
FSW	Female Sex Worker
HBM	Health Belief Model
HIV	Human Immune Deficiency Virus
HTLV	Human T-Lymphotropic Viruses
HSS	HIV Sentinel Surveillance
IBBA	Integrated Biological and Behavioral Assessments
ICHAP	India Canada Collaborative HIV/AIDS Project
IDUs	Injecting Drug Use(r)
II	In-depth-interviews
IOM	International Organization for Migration
ITPA	Immoral Traffic Prevention Act
KHPT	Karnataka Health Promotion Trust
KSAPS	Karnataka State AIDS Prevention Society
LAV	Lymphadenopathy Associated Virus
MSM	Men who have Sex with Men
NACO	National AIDS Control Organization
NACP	National AIDS Control Program
NGO	Non-Governmental Organization
PHCs	Primary Health Centers
SC	Schedule Caste
SITA	Suppression of Immoral Traffic in Women and Girls Act
SIV	Simian Immunodeficiency Virus
ST	Schedule Tribe
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infections
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNGASS	United Nations General Assembly Special Session
UNICEF	United Nations Children's Fund
USAIDS	United States Agency for International Development
WHO	World Health Organisation

CHAPTER-1



INTRODUCTION

CHAPTER 1

INTRODUCTION

1.1 Background

Migration is commonly identified as a key driver of the HIV epidemic (Deane, Parkhurst, & Johnston, 2010) and playing a significant role in the global, regional and local spread of the epidemic (Quinn TC, 1994; Webber, 2007). In many countries, migrant populations have shown higher level of HIV infection than those who do not move (Decosas, 1995; NACO, 2007). Extensive human migration can serve to expand HIV epidemics geographically by bridging high-risk sexual networks in multiple locations (Blanchard et al., 2005). However, HIV/AIDS and migration do not have a linear, cause-effect link, but they are known to be connected laterally (Bailey A, 2008). Circumstances under which migration takes places can increase the vulnerability of migrants to exploitation, violence, poor access to health care services and more importantly to HIV (Saggurti N, 2011). There are multiple conditions and factors that facilitate the spread of HIV/AIDS among mobile populations, indicating complex linkages between HIV and migration (Saggurti N, 2011). Migration has been a catalyst for the rapid spread of HIV and especially the migration and mobility of female sex workers (FSWs) would link the commercial sexual networks in HIV transmission. Therefore, understanding and addressing the issue of migration and HIV is an essential dimension of an effective response to HIV.

In 1986, the first case of Human Immunodeficiency Virus (HIV) was identified in Chennai, in India (Godbole & Mehendale, 2005). Since then, the epidemic has become one of the major public health problems in India. Several factors have been fueling the rapid spread of HIV/AIDS in India, including unsafe sex, low condom use, low

status of women, widespread stigma-discrimination and migration (NACO, 2014-15; WHO, 2013; WHO., 2011). The National AIDS Control Organization (NACO) estimate that as of 2014-15, the adult HIV prevalence in India is 0.29%, and about 2.39 million people were living with HIV/AIDS (NACO, 2013-14). HIV infection in India is higher among males (0.43%) than females (0.29%), and heterosexual transmission is responsible for almost 85% of infections (NACO, 2013-14). According to more recent annual sentinel surveillance, HIV epidemics are more severe in the north-eastern states, compared to the south Indian states where it is having a declining trend (NACO, 2012-13). The highest estimated adult HIV prevalence is found in Nagaland (1.29%), Mizoram (0.89%) and Manipur (0.60%). Whereas it is declining in South India states, mainly Andhra Pradesh (1.45% in 2003 to 0.35% in 2014-15), Karnataka (1.43% in 2003 to 0.36% in 2014-15), Maharashtra (1.15% in 2003 to 0.32% in 2014-15, and Tamil Nadu (0.83% in 2003 to 0.27% in 2014-15) (NACO, 2007, 2012-13, 2013-14, 2014-15). The overall HIV prevalence appears to be reducing among the general population in India. But still it is disproportionately high among high-risk groups, such as IDUs (7.14%), men who have sex with men (MSM) (4.43%), female sex workers (FSWs) (2.67%) and Sexually Transmitted Diseases (STDs) clinic attendees (3.6%) (NACO, 2013-14, 2014-15).

Female Sex Workers are an important determinant in the progress of HIV epidemic (Alary & Lowndes, 2004). In addition to them playing a prominent role, FSWs themselves are at higher risk of HIV (Alary & Lowndes, 2004; Lowndes et al., 2002). As per recent HIV Sentinel Surveillance (HSS) by NACO, the overall HIV prevalence among FSWs in India is 2.67%, especially in the three South Indian states namely; Maharashtra (6.89%), Andhra Pradesh (6.86%), and, Karnataka (5.10%) (NACO, 2014-15). Another study

found HIV prevalence among FSWs ranging between 2% and 38% (averaging at 14.5%) among the districts in four south Indian states of Andhra Pradesh, Maharashtra, Tamil Nadu and Karnataka (B. M. Ramesh et al., 2008). High-risk sexual behavior along with vulnerability factors which inhibit FSWs ability to adopt safer sexual behavior is an important factor for increased HIV prevalence among FSWs in India. It is observed that effective HIV and STI prevention among FSWs require both, programs that promote individual behaviour change and, structural interventions that alter the sex work environment in ways that promote reduction in vulnerability. This construct recognizes that FSWs are not necessarily the primary decision-makers for risk reduction behaviours (Example: partner reduction, condom use or utilization of health services). Instead, those who control the sex work environment such as pimps, brokers, madams, and clients are direct and indirect influencers on the autonomy of decision-making by FSWs. The situation is much difficult for FSWs, who frequently move since they move between different environments with varying levels of control and support. Furthermore, their mobility limits them to reach through outreach and education programmes designed to promote individual knowledge and skills in behaviour change strategies.

In India, a substantial proportion of female sex workers are mobile, both locally within and between states (Blanchard et al., 2005). Recent studies conducted in India, indicate that many sex workers move often and as frequently as every 2 weeks. This is a result of their search for work and also to escape from social stigma caused by family and community (Population Council, 2008a, 2008b, 2008c; Population Council & KHPT, 2008). Furthermore, mobile sex workers are likely to be more vulnerable to HIV due to inconsistent access to preventive programs and services (Quinn TC, 1994; Webber,

2007). Also, they are less able to adapt and negotiate safer sex practices due to lack of relationship with their clients and influence with those who control the sex work environment. Mobile sex workers are also less likely to have customers who are familiar with them either in person or from a socio-cultural perspective, and, therefore, might be less empowered to negotiate condom use, all of which are compounded by language barriers (Banandur et al., 2012).

Historically, a significant proportion of FSWs from Bagalkot, Vijayapura (earlier called Bijapur) and Belgaum districts in northern Karnataka, have worked in brothels in distant large cities of Maharashtra (Mumbai, Pune) and smaller and closer towns (Sangli, Satara, Kolhapur) just to the north of state boundary (Blanchard et al., 2005; O'Neil et al., 2004; T. R. Orchard, 2007). This has likely had a significant influence on the HIV transmission dynamics in the region since the HIV epidemic in cities such as Mumbai and Pune appears to have advanced earlier than elsewhere. So the large-scale movement of FSWs between the cities and the rural areas of Maharashtra and northern Karnataka has provided a potential bridge for HIV transmission in the rural areas of Bagalkot, Vijayapura and Belgaum districts. As per 2011 estimation by Karnataka State AIDS Prevention Society (KSAPS), high HIV prevalence was reported among the general population in Bagalkot (0.63%), Vijayapura (0.29%) and Belgaum (0.29%) districts. This is higher than India's national average (KSAPS, 2014). There are reports that FSWs migration fuels the HIV prevalence in northern Karnataka districts (Banandur et al., 2012). As per 2008 HSS, a very high HIV prevalence reported among FSWs in Bagalkot (34.33%) and Belgaum (16.4%) districts. Similarly, recent Integrated Behavioural and Biological Assessment (IBBA) by Karnataka Health Promotion Trust (KHPT) have also

reported a high HIV prevalence among FSWs in Belgaum urban (22.3%) and rural (14.%) (KHPT, 2013).

As per recent estimation of number of FSWs in the three districts, there are about 16,136 female sex workers in Bagalkot, Vijayapura and Belgaum together. Among them, more than 20% are migrant, who visit different places within and outside the district and state for sex work (KHPT, 2012). A huge variation found in the migration and mobility pattern of rural and urban FSWs in Bagalkot, Vijayapura and Belgaum districts and as yet, very little or no information is available about their profile, mobility patterns, factors influencing their migration and associated HIV risk and vulnerabilities. Also, until now there is very less emphasis on migrant FSWs to cover them for HIV prevention programs in this region. Thus, it is very much essential to understand the issues around FSW migration in this region. This information will significantly contribute to developing a setting specific intervention models that are sensitive to the circumstances of rural and urban FSWs in Bagalkot, Vijayapura and Belgaum districts in northern Karnataka.

In India, most studies involving migration are done on issues of international/cross-border movement and their vulnerability to HIV (Quinn TC, 1994; Rushing R, 2005; Shedlin MG, 2006). Studies on sex worker mobility and migration within the country and within or between states and their vulnerability to HIV/AIDS are limited. Those that deal with the issue of sex worker migration and vulnerability to HIV/AIDS either have small sample size involving convenience sampling (Ramesh BM, 2006; Wang B, 2007) or have been only qualitative studies (Brewer TH, 1998; O'Neil et al., 2004; Orchard, 2004; T.R Orchard, 2007). Studies have looked at broader contextual factors like war, famine, military coup among others as a reason for population migration (Quinn TC, 1994). Few studies have evaluated

reasons for migration among established sex workers. This study intends to answer some of these questions with a particular focus on within and/or between state movements of Female Sex Workers in northern Karnataka districts of Bagalkot, Vijayapura and Belagavi. This study aims to answer the following specific research questions:

1. What is the socio-demographic and sex work profile of female sex workers in northern Karnataka districts?
2. What is the migration and mobility pattern (places visited, reasons, frequency of visit, and duration of stay) of rural and urban FSWs in northern Karnataka districts?
3. Who are the people involved in the decision-making process related to FSWs first and subsequent visits to the different destinations?
4. What are the factors that influence out-migration of FSWs in northern Karnataka districts?
5. What is the nature of sexual behavior among FSWs in north Karnataka and its association with their increased risk and vulnerability to HIV/AIDS?

1.2 Study goal and objectives

The overall aim of this study is to enhance the knowledge about migration and mobility patterns, and associated HIV risk and vulnerabilities among rural and urban FSWs in northern Karnataka districts. The specific study objectives are,

1. To understand the socio-demographic, and sex work profile of rural and urban FSWs in three northern Karnataka districts.
2. To compare the migration and mobility patterns of rural and urban FSWs in three northern Karnataka districts.

3. To analyse the association between the individual, structural, environmental and cultural factors and the out-migration among FSWs in three northern Karnataka districts.
4. To analyze and describe the sexual behavior and associated HIV risk and vulnerabilities among FSWs in northern Karnataka.

1.3 Scope of the study

The present study solely focused on the female sex workers from Bagalkot, Vijayapura and Belgaum districts in Karnataka. Both rural and urban FSWs from the districts were interviewed for the study and comparisons were made between different characteristics of rural and urban FSWs. The study intent to describe the female sex workers socio-demographic and sex work profile, migration and mobility patterns, factors influencing the movement, people involved in the migration process, sexual behavior of FSWs in place of residence and the destination and its association on HIV transmission. But the study doesn't answer the questions related to HIV prevalence or incidence rate among FSWs and how migration is directly causing the HIV among FSWs.

The study utilized both quantitative and qualitative research techniques to answer the said research objectives, and the quantitative survey data was analyzed in the light of findings from the qualitative study. Quantitative data includes a survey of 2867 FSWs from three study districts, and the qualitative data consists of in-depth interviews and focused group (FGD) discussion with both rural and urban FSWs. The total sample also comprises a significant proportion Devadasi and non-Devadasi sex workers, and it contributed in comparing the sex work characteristics of Devadasi and non-Devadasi sex workers. The information collected for sex work, migration and sexual behavior are retrospective, and FSWs were asked to recall their sex work, migration and sexual behavior related information for the past one

year. The study has been more focused on the health consequences of FSW's migration and the aspects like poverty, stigma-discriminations, and changes in Devadasi traditions were less focused in this study.

1.4 Thesis organization

This thesis is organized into seven chapters. Chapter 1, Introduction; provides a preface of the study along with details of study objectives and the research questions.

Chapter 2, literature review and study framework; offers a background of the study and it includes a detailed literature review, concerning the three most important themes of the study: migration, female sex workers and HIV risk, and their interrelationships. The existing literature and empirical evidence in the field of migration, female sex workers and HIV/AIDS is discussed along with a review of the inter-relationships of migration as a risk factor for HIV among female sex workers. The literature review forms the context for this study and leads to its rationale and overall research goal.

Chapter 3 on methodology provides an overview of the different methods applied for data collection and analysis. Both qualitative and quantitative methods including the rationale for adopting sequential explanatory mixed methods approach have been described. A detailed description of study sites, study population, and the definition of the migrant, mobile and local FSWs is included in this chapter. Further, the chapter also presents sampling frame for quantitative and qualitative data collection, data analysis and data triangulation.

Chapter 4 presents results for the first research objective. Both quantitative and qualitative findings are presented in this chapter. For socio-demographic information, respondent's age, literacy level, religion, language speaks, marital status, age at marriage, the number

of children and household size are presented in detail. Similarly, for sex work characteristics, respondent's age at start of sex work, reasons for entering into sex work, duration in practicing sex work, and their income and other work apart from sex work were depicted comprehensively.

Chapter 5 presents findings for the research objectives two, and three, and intends to compare migration and mobility patterns and predictors for out-migration of FSWs from Bagalkot, Vijayapura and Belgaum districts in northern Karnataka. Findings from both quantitative and qualitative study are presented in this chapter along with comparisons made between rural and urban FSWs on their migration and mobility patterns. Also, findings are presented on association between the individual, structural, environmental and cultural factors and the out-migration of FSWs.

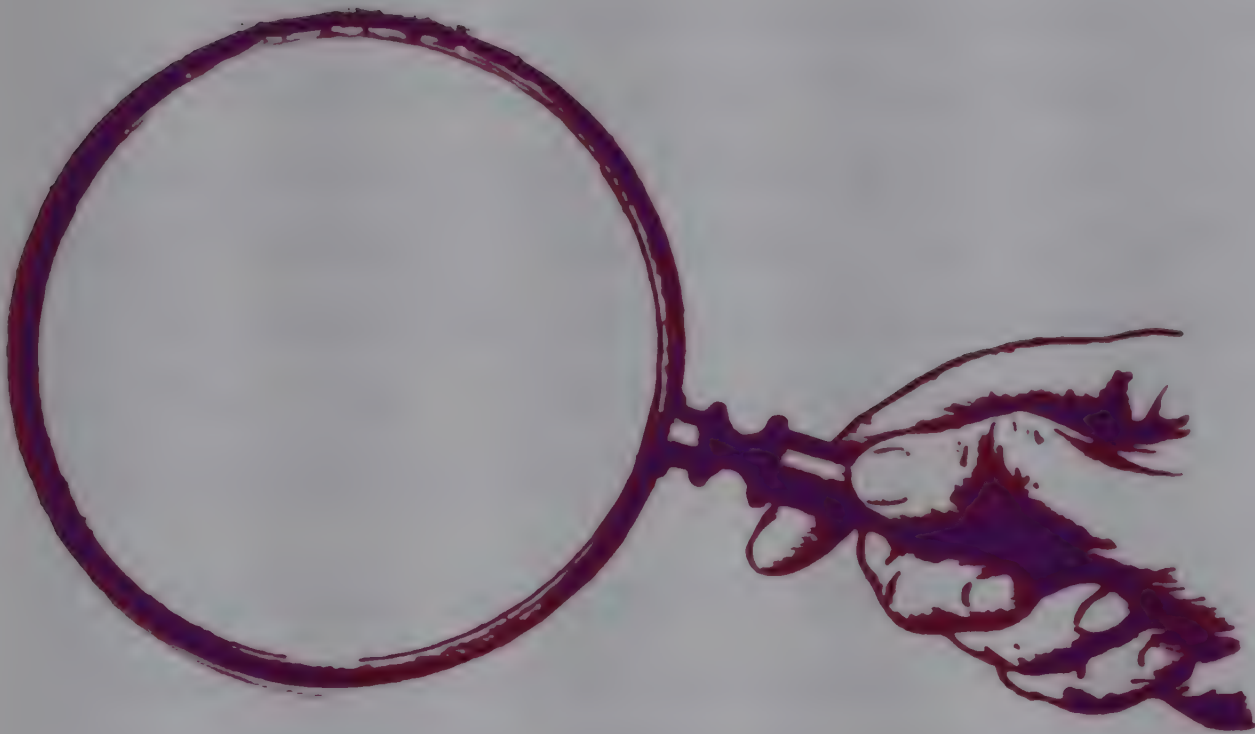
Chapter 6 presents the findings for fourth and last objective and aims to analyze and describe the sexual behavior and associated HIV risk and vulnerabilities among FSWs in place of residence and the different destinations they visit for sex work. Quantitative and qualitative findings related to the place of solicitation, place of entertaining clients, the source of clients, clients volume, type of sexual partner, the number of sex acts and the condom use pattern with different partners were presented. Also, the association between FSWs sexual behavior and related HIV risk and vulnerabilities were discussed comprehensively.

In Chapter 7, the key findings from the study and related program, research, and, policy implications are discussed. The chapter has been presented in two sub-headings; first, it begins with a discussion on the main observations and later, provides conclusions and recommendations. The study findings are compared and,

discussed in line with other available literature and highlights how it relates to previously identified outcomes. Also, this chapter provides insight on the implications of findings on future HIV prevention programs involving migrant FSWs in Karnataka and recommends few additional studies. The chapter ends with a brief description of strengths and limitations of the study.

The chapters followed by a reference list and appendix section. All the raw statistical analysis tables have presented in the appendix section. Appendix one and two is about the comparison of socio-demographic and sex work characteristics of rural and urban FSWs. Appendix three presents the bivariate analysis of the mobility patterns and determinants and appendix four and five is a bivariate analysis of behaviour, risk, and vulnerability of FSWs in place of residence and the most recent destination. Appendix Six presents the specifics on rapid mapping methodology used initially to identify FSWs in 3 study districts. Appendix seven contain participant information and consent form used for qualitative study and the eight and nine are interview guide and subject area for qualitative in-depth interviews and focused group discussion respectively. Appendix nine presents the seating chart and observations notes used for qualitative in-depth interviews and appendix ten is about quantitative survey questioner used for the study.

CHAPTER-2



LITERATURE REVIEW AND STUDY FRAMEWORK

CHAPTER 2

LITERATURE REVIEW AND STUDY FRAMEWORK

This chapter provides a literature review of migration, HIV/AIDS and Female Sex workers. A broader global review of the literature for each of these is followed up by a review of the India-specific literature for an understanding of how the situation in India fits into a broader global context. It helps in contextualizing the issues and throws light on how socio-cultural factors affect migration, HIV/AIDS and Female Sex Workers.

The chapter has divided into four sections. Section I, titled 'Conceptual and Theoretical Understanding of Migration' contains the review of the literature on the meaning and definitions of migration and the migration theories. Section II, titled 'HIV/AIDS' provides the meaning and origin of HIV/AIDS and the epidemiological scenario of HIV/AIDS on the global level and also particular to India and Karnataka. Section III, titled 'Sex Work' contains the definitions and perspectives about sex work at different periods including ancient India, colonial India, and the contemporary India. This section also describes the features of *Devadasi* culture and the sex work scenario in Karnataka. Section IV, with the title 'linking the epidemic: migration, female sex workers and HIV transmission' binds migration, HIV/AIDS and sex work together and describe a framework for this study.

Literature specific to India and globally has discussed in this section on the issue of migration and its role in HIV transmission. Female migration issues also discussed in the section along with a theory of how migration itself is not a risk factor, but the process of

migration and integration of migrant population into the local communities can expose the migrant to the risk of HIV/AIDS. In the end, this section outlines the study rationale that the study intends to achieve.

2.1 Conceptual and theoretical understanding of migration

2.1.1 The concept of migration and its definitions:

The word “migration” has derived from the Latin word “migratio”. It means a physical movement of humans from one area to another, with the intention of settling in the new location (Oxford English Dictionary, 1909). Archaeological evidence suggests that the most primitive human beings on earth lived in Africa. Then they moved over many thousands of years until they eventually settled, on the whole, planet (McNeil, 1984). Migrations have occurred throughout human history and historically, this movement was nomadic, often causing significant conflict with the indigenous population and their displacements and cultural assimilation. Migration has continued under the form of both voluntary movements within one's regions, country or beyond and in forced migration, which includes the slave trade, trafficking human beings and ethnic cleansing. People who migrate to a territory called immigrants while, at the departure point, they are called emigrants. Small populations are migrating to develop a territory considered void of settlements while communities displaced by immigration and colonization are called refugees (McNeil, 1984).

According to International Organization for Migration (IOM) , "Migration is the movement of a person or a group of individuals, either across an international border or within a state" (Perruchoud, 2011). It is a population movement, encompassing any movement of people, whatever its length, composition and causes; it includes

migration of refugees, displaced persons, economic migrants, and people moving for other purposes, including family reunification (Perruchoud, 2011).

A person who moves from one place to another, to find work or better-living conditions is called, "migrants"(Perruchoud, 2011). IOM has stated that, at the international level, no universally accepted definition of "migrant" exists. The term migrant was usually understood to cover all cases where the decision to migrate was taken freely by the individual concerned for reasons of "personal convenience" and without an intervention of an external compelling factor. It, therefore, applied to persons, and family members, moving to another country or region to improve their material or social conditions and also improve the prospect for themselves or their family (Perruchoud, 2011).

The UN Convention on the Rights of Migrant defines a migrant worker as a “person who is to be engaged, is engaged or has been engaged in a remunerated activity in a state of which he or she is not a national” (UNESCO, 2005). But, this definition does not refer to refugees, displaced or others forced or compelled to leave their homes.

Similarly, the Special Repporteur of the Commission on Human Rights has defined the migrants as “persons who are outside the territory of the State, of which they are nationals or citizens, are not subject to its legal protection and are in the territory of another State” (United Nations Human Rights, 2015).

The government of India's, the office of the Registrar General and Census Commissions of India has defined the migrant as, "a person who has moved from one politically defined area to another similar area" (Census of India, 2014; Vemuri, 1997). In the Indian

context, these areas are a village in rural areas and a town in urban areas. Thus, a person who moves from one village/town to another village/town is termed as a migrant. However, this only provided his/her movement is not of purely temporary nature on account of casual leave, visits, tours, etc. (Census of India, 2014; Office of the Registrar General and Census Commissioner, 2011; Vemuri, 1997).

These definitions indicate how difficult it is to define what constitutes a migrant and thus how national legislations differ by their understanding of the terms. However, certain commonalities can be underlined such as movement, purpose, duration. When the term looked at from the global perspective, it often signifies movement between countries. But the nature of migration is mostly local and regional in the study context (Walter DSouza, 2003).

Most countries distinguish between many categories in their migration policies and statistics. The variations existing between countries indicate that there are no objective definitions of migration. The dominant forms of movement can distinguish based on the motives (economic, family reunion, refugees) or legal status (asymmetrical migration, controlled or free emigration/immigration) of those concerned (Walter DSouza, 2003). In summary, migration is not a single act of crossing the border. Rather it is a continuous process, and it affects all aspects of the people involved in migration.

2.1.2 Migration theory:

Over the past centuries, migration has emerged as a major force throughout the world, and it has attracted the attention of sociologists, economists, geographers, public health specialists and other social thinkers. The primary concern of sociologists had been to examine factors influencing the individual and household decision for migration. They have discussed demographic, social, physiological,

economic and attitudinal factors to explain the migration flows (Lee, 1966; D. S. Massey, Arango, Hugo, J.G. Kouaouci, Pellegrino, A.A. Taylor, J.E 1993). The economists have focussed their attention on the causes and consequences of migration. They have also been discussing the role of wages, income, levels of employment and unemployment influencing migration flows (D. S. Massey, Arango, Hugo, J.G. Kouaouci, Pellegrino, A.A. Taylor, J.E 1993). Geographers are mostly concerned with the movement of people in space and territorial redistribution of the population (D. S. Massey, Arango, Hugo, J.G. Kouaouci, Pellegrino, A.A. Taylor, J.E 1993). Also, public health specialists have been focusing on different communicable diseases and its relationships with people migrations, and a great deal of literature devoted to this issue (Caldwell, 1997; Decosas, 1995; Haour-Knipe, 1996; Herdt, 1997).

Many theoretical models have proposed to explain and examine the reasons for internal and international migration and its effect on both sending and receiving countries. However, according to Massey et al. research into migration lacks a commonly accepted theoretical framework. Also, as of now, there is no single, coherent theory of migration (Massey, 1988; D. S. Massey, Arango, J., Hugo, G., Kouaouci, A., Pellegrino, A. Taylor, J.E. , 1993).

Broadly, migration theories can be classified into three broad categories: Initiation theories of migration, continuation theories of migration and historical theories of migration. Initiation theories of migration include neoclassical economic theory, new economic of labour migration, dual labour market theory, world-system theory, relative deprivation theory. The continuation theories of migration include network theory, institutional theory and cumulative causation theory. Historical migration theories include Earnes Ravenstein's law of migration, Lewis linear model of migration and Lee's push-pull

theory. Each of these theories has briefly described below (Lewis, 1954; D. S. Massey, Arango, J., Hugo, G., Kouaouci, A., Pellegrino, A. Taylor, J.E. , 1993; Ravenstein, 1885).

Initiation theories of migration:

The neoclassical economic theory is the oldest and best-known theory of migration and originally developed to explain labour movement in the process of economic development (Harris, 1970; Lewis, 1954; Ranis, 1961). It states that wage differences between regions are the main reason for labour migration. Also, such wage differences are due to geographic differences in the supply of and demand for labour (Jennissen, 2007; D. S. Massey, Arango, J., Hugo, G., Kouaouci, A., Pellegrino, A. Taylor, J.E. , 1993). According to this theory, countries with a shortage of labour capital have a high equilibrium wage, whereas countries with a relatively large labour supply have a low equilibrium wage. Due to these wage differences, labour flows take place from low wage to high wage countries (Borjas, 2008; Jennissen, 2007; D. S. Massey, Arango, J., Hugo, G., Kouaouci, A., Pellegrino, A. Taylor, J.E. , 1993). Often, with this flow of labour come changes in the sending as well as the receiving country.

The new economic theory of migration has challenged many assumptions and conclusions of neoclassical theory. Stark and Bloom have developed this theory, and they argue that, the decision to become a labour migrant cannot be explained solely at the level of individual workers and their economic incentives, but that wider social entities must be taken into account as well (Stark, 1985). The principal argument of the new economic theory is individuals do not make migration decisions in isolation, but collectively by families or households. Families send workers abroad not only to improve income in absolute terms, but also to increase income about other families,

and, hence to reduce their relative deprivation compared with some reference group. Moreover, the decisions of migrants are influenced by a set of factors that shaped by conditions in the home country (Brettell, 2000; Stark, 1985; Vetrovec, 2010).

According to Piore, immigration is not caused by push factors in sending countries, but by pull factors in receiving countries (Piore, 1979). This approach is called labour market theory. The labour market theory assumes that the labour markets in developed countries consist of two segments: primary, which requires high-skilled labour, and secondary, which is very labour intensive but needs low-skilled workers. The theory argues that migration is driven by conditions of labour demand rather than supply: the character of the economy in developed countries creates a demand for low-skilled jobs that domestic workers refuse and this creates a need for migrant labour from developing countries (Morawska, 2007; Piore, 1979; Ranis, 1961).

According to world systems theory, migration is a natural outgrowth of disruptions and dislocations that inevitably occur in the process of capitalist development. The penetration of capitalist economic relations into peripheral, non-capitalist societies creates a mobile population that is prone to migrate aboard (Froebel, 1980; Morawska, 2007; Wallerstein, 1974, 1979).

Relative deprivation theory argues that the relative income position of a household or an individual is an important determinant of international migration. Awareness of other member or family in the sending society about income differences is a significant factor about migration. The incentive to emigrate will be higher in the society that experiences much economic inequality (Jennissen, 2007). According to relative deprivation theory, there are two stages of migration for a

worker: first, they invest in human capital formation, and then they try to capitalize on their investments. In this way, successful migrants may use their new capital to provide for better schooling for their children and better homes for their families (Jennissen, 2007; D. S. Massey, Arango, Hugo, J.G. Kouaouci, Pellegrino, A.A. Taylor, J.E 1993).

Continuation theories of migration

The network theory of migration does not look at the determinants that initiate movement but rather at what perpetuates migration in time and space (Brettell, 2000; D. S. Massey, Arango, J., Hugo, G., Kouaouci, A., Pellegrino, A. Taylor, J.E. , 1993; Vetovec, 2010). Migrant networks are sets of interpersonal ties that connect migrants, former migrant, and non-migrants in origin and destination areas through ties of kinship, friendship and common community background. Migrant networks help potential migrants by sponsoring their journey expenses, finding a job and safe accommodation, providing information about social security and education possibilities. By doing this, the network will reduce the costs and risks of movement and increase the expected net return from migration. This dynamic theory accepts the view of international migration as an individual or household decision process. But argues that act of migration at one point in time systematically alter the context within which future migration decisions are made, significantly increasing the likelihood that later decision makers will choose to migrate(Brettell, 2000; Hear, 2010; D. S. Massey, Arango, J., Hugo, G., Kouaouci, A., Pellegrino, A. Taylor, J.E. , 1993; Vetovec, 2010).

According to Institutional migration theory, International migration can be institutionalized once it occurs on a large scale. The institutional theory argues that a large inflow of international migrants can encourage profit and non-profit organization to act on issues

created by migration. Profit organization and private entrepreneurs provide a range of services to migrants in exchange for fees, for instance, surreptitious smuggling across borders, labour contracts, counterfeit documents and visas, arranged marriages between migrant and legal resident, lodging, credit, etc. Simultaneously, humanitarian groups help migrant by providing counselling, social services, shelter, and legal advice about getting legitimate papers and even insulation from immigration law enforcement authorities. Over a period, a stable Institute will form, and that will act as another form of social capital that migrants can draw upon to gain access to the foreign labour market (Brettell, 2000; D. S. Massey, Arango, Hugo, J.G. Kouaouci, Pellegrino, A.A. Taylor, J.E 1993).

Myrdal et al. argue that sustainability of international migration can make further movement progressive for over time, and this process has been called cumulative causation (Myrdal, 1957). Social scientists have identified six socioeconomic factors that are potentially affected by migration in this cumulative fashion. It includes distribution of income, distribution of land, organization of agriculture, culture, regional distribution of human capital and the social meaning of work (Brettell, 2000; Hear, 2010; Stark, 1985; Taylor, 2001; Vetrovec, 2010).

Historical theories of migration

One of the earliest researchers to work on migration was Ernest Ravenstein. He developed the 'Laws of Migration' based on census data from England and Wales in 1885 (Molho, 1986; Ravenstein, 1876, 1885). Ravenstein's laws state that the primary cause for migration was better external economic opportunities and the volume of migration decreases as distance increases. Also, migration occurs in stages instead of one long move, and population movements are

bilateral, and migration differentials (e.g., gender, social class, age) influence a person's mobility (Ravenstein, 1876, 1885).

Lewis gave a 'linear model of migration' in 1954. He explained migration regarding differential supply and demand of labour in different regions/areas (Lewis, 1954; Vetrovec, 2010). Lee, in 'push-pull' theory, wrote that migration took place from less endowed areas to well-endowed areas through 'push' created by poverty and lack of work and the 'pull' created by better wages in the destination (Brettell, 2000; Lee, 1966; Vetrovec, 2010).

By the theories reviewed above, it can be concluded that there is not a universal theory or principle that can explain different types of migration. Most of the migration models and explanations situated within a 'positivistic rational' paradigm, the dominant theoretical paradigm in the 19th and 20th centuries. Migration understood regarding a linear movement, which follows the cause-effect model, and explained in a mechanical-rational way. Poverty, lack of opportunity and surplus of labour in rural areas and high labour demand in urban areas due to the expansion of industries cause people to respond mechanically to move from less developed areas to more developed areas. Migrant, in these models, is rational in his decision-making and mechanical in response to external conditions. However, these explanations fail to take into account the imperfections and intricacies of different labour markets. This understanding of migration also neglects the social context in which individual decisions are made, the perceptions of the potential migrants of the wage differentials, and the availability of means to act upon them (Brettell, 2000; Portes, 2010; Vetrovec, 2010; Walter DSouza, 2003).

2.2 HIV/AIDS

2.2.1 What is HIV/AIDS?

Acquired Immunodeficiency Syndrome (AIDS) caused by the Human Immunodeficiency Virus (HIV). HIV is a virus that cannot grow or reproduce on their own and they need to infect the cells of a living organism to replicate (make new copies of themselves) (CDC, 2014). Once the HIV enters into the human body, it gradually attacks immune system cells and progressively damages the immune systems cells (Avert, 2014; Cunningham, 2010). Then body becomes more vulnerable to infections, and this advanced stage of HIV infections called as AIDS (Douek, 2009). AIDS is not a single disease but a complex condition where many different diseases can occur alone or together because of the decreased immunity in the body (Aids.gov, 2014; Avert, 2014; Douek, 2009).

HIV found in the blood and sexual fluids of an infected person, and in the breast milk of an infected woman (CDC, 2014; Douek, 2009). HIV transmission occurs when a sufficient quantity of these fluids get into someone else's bloodstream (Avert, 2014), and there are four main ways a person can become infected with HIV: 1. Unprotected sexual intercourse with an infected person 2. Sharing infected needles through intravenous drug use 3. Transfusion of infected person's blood or blood products and 4. From an infected woman to her baby during pregnancy, delivery and breastfeeding (Avert, 2014; CDC, 2014; WHO, 2014). Often people who infected with HIV don't have any symptoms at all. But some people may experience the flu, develop a rash or get swollen glands for soon after they become infected with HIV. However, these are also a common symptom of other less severe illness and so that, it 's hard to tell just by looking if someone has infected with HIV. The only way of identifying someone infected with HIV is through a blood test (AIDSinfo, 2014; Avert, 2014; WHO, 2014).

A person who diagnosed as HIV positive can lead a normal life for 8 – 10 years (without any treatment) before showing any signs or symptoms of AIDS (UNAIDS, 2007). Once the person has developed an AIDS-related condition, the symptoms are called opportunistic infection (Avert, 2014). The infections are described 'opportunistic' because they take advantage of the opportunity offered by a weakened immune system. The common opportunistic infections are; sudden loss of weight, fever, diarrhoea for an extended period, persistent cough, ulcers in mouth/throat and skin tumors'(Avert, 2014; Weiss RA, 1993).

2.2.2 The origin of HIV/AIDS:

The origin of HIV&AIDS has mystified the scientists ever since the illness first came to light in the early 1980s (Avert, 2014). The first recognized cases of AIDS occurred in the United States of America (USA) in the early 1980s (CDC, 1981). Some gay men in New York and California had developed a rare opportunistic infections and cancers that seemed stubbornly resistant to any treatment (CDC, 1981). At this time, AIDS did not yet have a name, but it quickly became evident that all of them were suffering from a common syndrome (Osmond, 2003). The acronym AIDS suggested at a meeting in Washington, D.C in July 1982(Time, 2003) and Centre for Disease Control (CDC) had clearly defined this on September 1982 (Herman R, 1982; McKeown P, 1982; MMWR Weekly, 1982).

A year later in 1983, two separate research group led by Dr. Robert Gallo and Dr. Luc Montagnier have independently declared that a novel retrovirus may have been infecting AIDS patients and published their findings in 'science' journal (Bailes, 2003; Gao F, 1999). Gallo's group called their newly isolate virus human T-lymphotropic viruses (HTLV-III) and Montagnier's group named their isolated virus lymphadenopathy-associated virus (LAV). As this two

virus turned out to be the same, LAV and HTLV-III renamed as HIV in 1986 (Barre-Sinoussi, 1983; Basavapathruni, 2007; Gao, Bailes, & Robertson, 1999; Lévy, 1993; RC Gallo, 1983).

HIV is a 'lentivirus' and lentiviruses are part of a larger group of viruses known as retroviruses, in simple word, a virus can only survive in a human body (Weiss RA, 1993). The name 'lentivirus' literally means 'slow virus', and this is because it takes a long time to produce any adverse effects in the body (Avert, 2014). They have found in some different animals, including cats, sheep, horses and cattle. However, the most interesting lentivirus concerning the investigation into the origins of HIV is the 'Simian Immunodeficiency Virus' (SIV) that affects monkeys, which is believed to be at least 32,000 years old (Worobey, 2010). Studies have proved that HIV is a descendant of a Simian Immunodeficiency Virus, and initially, it was transmitted from animals (P. Sharp, Hahn, BH 2011). The viral transfer between animals and humans known as 'zoonosis'. Several theories were developed explaining how this zoonosis took place, and how SIV became HIV in humans (Gao et al., 1999; Keele et al., 2006; P. B. Sharp, E; Chaudhuri, RR; Rodenburg, CM; Santiago, MO; Hahn, BH, 2001).

Hunter' theory has been most renowned and commonly accepted a theory of zoonosis. This theory argues that SIV transferred to human as a result of chimps being killed and eaten or their blood getting into cuts or wounds on the hunter. It further says, hunter's body would have fought off SIV, but in few occasions it adapted itself within its new human host and became HIV(Kalish ML, 2005). It quotes several anecdotal pieces of evidence about early strains of HIV, each with a slightly different genetic make-up would support this theory: every time it passed from a chimpanzee to a man, it would have developed in a slightly different way within his body, and thus

produced a slightly different strain (Wolfe, 2004).

The *oral polio vaccine theory* discovered by journalist Edward Hooper and in his book 'The River', he argues that HIV can be traced to the testing of an oral polio vaccine called 'Chat', given to a million people in the late 1950s. He further argues that Chat vaccine was cultivated using chimps kidney cells taken from local chimps infected with SIV. He claims the vaccine would have resulted in the contamination of chimps SIV, and a large number of people subsequently becoming infected with HIV. But studies that examine the eyewitness, historical documents of the time, epidemiological analysis, and analysis of ancillary phylogenetic, virological and polymerase chain reaction data concluded that the hypothesis of this theory has been false (Birmingham K, 2000; Cohen J, 2000; Gellin B, 2001).

The *contaminated needle theory* is an extension of the original hunter theory, and it says, usage of contaminated syringes by African healthcare professional might have caused the rapid transmission of viral particles from one person to another (Avert, 2014).

The *colonialism theory* is one of the most recent theories, proposed by Jim Moore in the year 2000. He argues that, during the late 19th and early 20th century, much of Africa was ruled by colonial forces. In areas such as French Equatorial Africa and the Belgian Congo, colonial rule was particularly harsh, and many African forced into labour camps where sanitation was poor, the food was scarce and physical demands were extreme. These factors created ill health among labourer, and so SIV could easily have infiltrated the labour force and taken advantage of their weakened immune systems to become HIV (Avert, 2014; Chitnis, 2000).

The conspiracy theory argues that HIV was 'man-made' and it manufactured as part of a biological warfare programme. Many African Americans who took part in a cross-sectional telephonic survey said that HIV is a man-made, and it produced in a Government laboratory. They also believed HIV was created and spread by the Central Intelligence Agency and AIDS is a form of genocide against black people (Avert, 2014; Bogart & Bird, 2003; Fears, 2005). But, these hypotheses have been rejected by scientific consensus.

All these theories are individual driven, and there is no exact idea about who the first person infected with HIV was or how it spread from that first person. Today's pressing need is not investigating the epidemic origin but instead, providing an effective treatment for people infected with HIV, develop effective strategies to prevent the further spread of HIV and to ensure that similar pandemic never occurs again.

2.2.3 The epidemiology of HIV/AIDS:

Global scenario of HIV/AIDS:

As per UNAIDS estimations, globally 35.3 million people are living with HIV. It consist 32.1 million adults, 17.7 million females and 3.3 million children under the age group of fifteen. In 2012 alone, there around 2.3 million people were newly infected with HIV, and it includes, 2 million adults and 2, 60,000 children under five. Also, 1.6 million AIDS-related deaths have been recorded in 2012 (UNAIDS, 2013a).

World Health Organization estimates, there were about 6,300 new HIV infections a day in 2012, and about 95% of these infections have occurred in low and middle-income countries. Out of 6,300 new infections, about 700 are children less than 15 years of age and about

5500 are adults. Also, among adults, 47% are women and about 39% are young people between the age group of 15 to 24 (WHO, 2013; WHO., 2011)

Since the start of the epidemic, an estimated 36 million people have died of AIDS-related illness (WHO, 2012). Below table provides (Table 1) a cumulative statistics of people living with HIV, new HIV infections among children & adults, the number of people accessing treatment, AIDS-related deaths and the resource allocation to address the challenges posed by HIV/AIDS from 2001 to 2012 (UNAIDS, 2013a).

Table 1: Global statistics of HIV/AIDS from 2001 to 2012

	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
People living with HIV	30.0 million [27.3-33.1 million]	31.0 million [28.2-34.1 million]	31.7 million [28.9-34.8 million]	32.2 million [29.4-35.3 million]	32.5 million [29.7-35.6 million]	32.8 million [30.1-36.0 million]	33.2 million [30.4-36.3 million]	33.5 million [30.7-36.7 million]	34.0 million [31.1-37.1 million]	34.4 million [31.5-37.7 million]	34.9 million [31.9-38.3 million]	35.3 million [32.2-38.8 million]
New HIV infection (Total)	3.4 million [3.1-3.7 million]	3.3 million [3.0-3.6 million]	3.1 million [2.9-3.5 million]	3.0 million [2.7-3.3 million]	2.9 million [2.6-3.2 million]	2.8 million [2.5-3.2 million]	2.7 million [2.4-3.1 million]	2.6 million [2.3-3.0 million]	2.6 million [2.2-3.0 million]	2.5 million [2.2-2.9 million]	2.5 million [2.1-2.9 million]	2.3 million [1.9-2.7 million]
New HIV Infections (Adult)	2.8 million [2.6-3.1 million]	2.7 million [2.5-3.0 million]	2.6 million [2.3-2.9 million]	2.4 million [2.2-2.7 million]	2.3 million [2.1-2.6 million]	2.3 million [2.0-2.6 million]	2.2 million [2.0-2.5 million]	2.2 million [1.9-2.5 million]	2.2 million [1.9-2.5 million]	2.2 million [1.9-2.5 million]	2.2 million [1.8-2.5 million]	2.0 million [1.7-2.4 million]
New HIV infections (Children)	550 000 [500 000–620 000]	560 000 [510 000–630 000]	560 000 [520 000–630 000]	550 000 [510 000–620 000]	540 000 [490 000–610 000]	520 000 [470 000–580 000]	480 000 [440 000–550 000]	450 000 [410 000–520 000]	400 000 [360 000–470 000]	360 000 [330 000–420 000]	310 000 [280 000–370 000]	260 000 [230 000–320 000]
AIDS-related deaths	1.9 million [1.7-2.2 million]	2.1 million [1.9-2.4 million]	2.2 million [2.0-2.5 million]	2.3 million [2.1-2.6 million]	2.3 million [2.1-2.6 million]	2.3 million [2.0-2.6 million]	2.2 million [1.9-2.5 million]	2.1 million [1.8-2.4 million]	2.0 million [1.7-2.3 million]	1.9 million [1.7-2.2 million]	1.8 million [1.6–2.1 million]	1.6 million [1.4-1.9 million]
People accessing treatment					1.3 million	2.0 million	2.9 million	4.1 million	5.3 million	6.6 million	8.1 million	9.7 million
Resources		US\$ 3.8 billion	US\$ 4.6 billion	US\$ 5.7 billion	US\$ 7.4 billion	US\$ 8.8 billion	US\$ 10.5 billion	US\$ 14.6 billion	US\$ 15.5 billion	US\$ 15.6 billion	US\$ 17.1 billion	US\$ 18.9 billion

Source: UNAIDS 2013 Global Fact Sheet

These numbers explain the seriousness of the disease, and it clearly indicates that, HIV/AIDS is no more a mere health crisis, but it is development and security crisis too. It has a severe impact on rates of infant, child and maternal mortality, life expectancy and economic growth. This, in turn, has resulted in an excessive burden of suffering among individuals and households. Therefore, providing adequate and affordable treatment and care to people living with HIV and enabling people who have not acquired the virus to protect them against the HIV are the biggest areas in need of intervention.

Despite these challenges, there have been successes and promising signs as well. New global efforts have been mounted to address the epidemic, particularly in the last decade (UNAIDS, 2013c). Prevention has helped to reduce HIV prevalence rates in a small, but growing number of countries and new HIV infections are believed to be on the decline (UNAIDS, 2012f). As indicated in the above table, there were 2.3 million new HIV infections in 2012, and this is the lowest number of annual new infections since the mid-to-late 1990s when approximately 3.5 million people were acquiring HIV every year (UNAIDS, 2013a, 2013b). The number of HIV infections declined by more than 50% in 26 countries between 2001 to 2012 and between 25% and 49% in an additional 17 countries (UNAIDS, 2013a). The drop in new HIV infections is most pronounced among children. From 2001 to 2012, the number of children newly infected with HIV declined by 52% from 5, 50,000 in 2001 to 2, 60,000 in 2012 (WHO, 2014). Decreased cost of first-line antiretroviral therapy and increased political commitment and smarter and increased investments (US\$3.8 billion in 2001 to US\$18.9 billion in 2012) and imperative programming led to a record of 9.7 million people having access to antiretroviral therapy at the end of 2012. This resulted in the number of people dying from AIDS-related causes each year has

declined from a high of 2.3 million in 2005 to 1.6 million in 2012 (UNAIDS, 2013b, 2013c; WHO, 2014).

The global burden of HIV/AIDS varies, and the countries social, cultural, economical and also demographic characteristic plays a significant role in increased risk of HIV epidemic (Luger, 1998). It becomes essential to understand the extent and intensity of the disease in each specific region.

Sub-Saharan Africa is more heavily affected by HIV and AIDS than any other region of the world (UNAIDS, 2012f). As per 2012 estimation, there are about 25 million people are living with HIV, and this is almost two-thirds of the global total. HIV prevalence among the adult population in sub-Saharan Africa is 4.7% and in the year 2012 only, there are about 1.6 million new HIV infections identified and around 1.2 million people died due to AIDS-related illness (UNAIDS, 2012f, 2013a).

HIV prevalence and people dying from AIDS are varying between African countries. Adult HIV prevalence in Zambia, Namibia and Zimbabwe is around 10-15%, whereas this is less than 1% in Somalia and Senegal (UNAIDS, 2013c). Southern Africa is the worst impacted by HIV/AIDS and four southern African countries namely; South Africa, Lesotho, Botswana, and Swaziland have recorded the highest adult HIV prevalence of 17.8%, 23.6%, 24.8%, and 25.9% respectively (Avert, 2014; UNAIDS, 2013c). Similarly, West African countries have been less affected by HIV/AIDS (Ex: Cameroon 5.3%, Gabon 5.2% and Nigeria 3.6%) and adult HIV prevalence in East African countries namely Uganda, Kenya and Tanzania has exceeds 5% (UNAIDS, 2013c).

HIV/AIDS has created a lot of social and economic consequences, and its effects widely felt, not only on health sector but also in education, industry, agriculture, transport, human resource and the economy in general. The AIDS epidemic in sub-Saharan Africa continues to devastate communities, rolling back decades of development progress (Avert, 2014; UNAIDS, 2011, 2013c).

Most of the Asian countries have not felt the heat of HIV/AIDS until 1990 and by the end of the decade HIV was rapidly spreading in many areas of Asian continent (Avert, 2014). As per 2012 estimates, there are about 4.7 million people are living with HIV with an adult prevalence of around 0.4% in South, East and South-East Asia. Also, around 2, 81,000 new HIV infections were detected and 2, 61,000 people died due to AIDS-related illness in the year of 2012 only (UNAIDS, 2013a, 2013b, 2013c).

There are three main HIV transmission routes in Asia, namely; unprotected paid (and unpaid) sex, Injecting drug use and sex between men(The Commission on AIDS in Asia 2008; UNAIDS, 2009; WHO., 2011). Both paid and unpaid unprotected sex accounts for a significant share of new HIV infections in many Asian countries. Low condom use among clients of sex workers has contributed to a high HIV prevalence among sex workers and their clients. Injecting drug use is an important driving factor in the spread of HIV throughout Asia, notably in China, Indonesia, Malaysia and Vietnam (UNGASS, 2012). Sex between men is still a prominent feature of HIV transmission in many Asian countries. MSM in Asia do not identify themselves as gay because of cultural norms that discourage homosexuality, and the hidden nature of MSM activity has been serving as a bridge for HIV to spread into the broader population (UNAIDS, 2006, 2012e; WHO/UNAIDS/UNICEF, 2011).

HIV prevention efforts have been remarkably successful in many Asian countries. Well funded, politically supported campaigns have led to significant declines in HIV infection. But to stabilize the growing epidemic, lot more needs to be done; specifically intervention coverage with sex workers, IDUs and MSM needs to increase. A lot more has to be done to decrease the stigma and violence against women and increase the coverage of prevention of mother to child transmission.

Recent estimates indicate that around 1.5 million people are living with HIV with an adult prevalence of 0.4%. There are about 86,000 new HIV infections were detected and around 56,000 people died due to AIDS-related illness in 2012 (WHO/UNAIDS/UNICEF, 2011). Ways and extent of HIV epidemic in Latin American countries vary and poverty, migration, homophobia and HIV-related stigma and discriminations are greatly affecting to overcoming the crisis (UNAIDS, 2010, 2012b). As compared to many African countries, HIV prevalence in Latin American countries is relatively low. But, the number of people affected is still substantial, and the prevalence remained constant since 2001 to 2011 (UNAIDS, 2011, 2012a, 2013c; WHO., 2011). More than half of people living with HIV reside in four largest countries of Latin America namely; Brazil, Colombia, Mexico and Argentina. The most severe epidemics found in smaller countries such as Belize, Guyana and Suriname, which have an HIV prevalence of 2.3%, 1.1% and 1.0% respectively (UNAIDS, 2013c). The majority of countries in the region have less than 1 percent of HIV prevalence but the prevalence among specific groups, such as men who have sex with men, sex workers, injecting drug users and migrants often very high.

Around 1.3 million people are living with HIV with an adult prevalence of 0.5% among North American countries. An estimated

48,000 people newly infected with HIV and 20,000 people died due to AIDS-related illness in 2012. Interestingly, most of these new infections occurred in the United States of America. According to the United States Centers for Disease Control (CDC) and Prevention, the HIV incidence in the United States has been relatively stable in the past few years, with between 48,600 and 56,000 people acquiring HIV infection annually between 2006 and 2009 (Prejean et al., 2011). Unprotected sex between men continued to be the primary driver of HIV transmission in this region, with injecting drug use and unprotected paid sex being minor factors (Hall et al., 2008; Prejean et al., 2011; Purcell, 2010). In Canada, Aboriginal people continue to be overrepresented in the HIV epidemic (WHO/UNAIDS/UNICEF, 2011). Aboriginal people represent less than 4% of Canada's population, but they accounted for 8% of the total number of people living with HIV and almost 13% of the people newly infected in 2008. Injecting drug use was the principal cause of HIV infection among Canadian aboriginal people (Public Health Agency of Canada., 2010).

After sub-Saharan Africa, the Caribbean has a higher HIV prevalence than any other region in the world with 1 percent of the adult population infected (UNAIDS, 2012b). In 2012, an estimated 12,000 people in the Caribbean became infected with HIV and around 11,000 died of AIDS (WHO/UNAIDS/UNICEF, 2011). A total of 2,500,000 people are living with HIV in this region. The main route of HIV transmission is through unprotected heterosexual sex with some extent of men having sex with men and a very minimum through injecting drug use. Poverty, gender inequalities, HIV-related stigma and migration between islands play a background role in HIV transmission. Women in this region are more vulnerable and more than half of people living with HIV are women (UNAIDS, 2012b, 2012d).

Some of the countries namely; Bahamas, Jamaica, Haiti, Trinidad and Tobago had above 1.5 percent of HIV prevalence (UNAIDS, 2012e). Sex tourism plays an important role, and HIV prevalence amongst sex workers varies across the region, from 1 percent in Cuba, up to 17 percent in Guyana (UNAIDS, 2012a, 2012e). Men having sex with men have legally prohibited in this region and homophobia, cultural taboos about MSM remain significant barriers to reaching this group of prevention campaigns (International Lesbian, 2012; UNAIDS, 2012a, 2012e). Some of the Caribbean regions found highest HIV prevalence among MSM communities namely Haiti 18.2 percent, Guyana 19.4 percent and Jamaica 38 percent (International Lesbian, 2012; UNAIDS, 2012a).

According to UNAIDS estimates, around 2.1 million people were living with HIV in the European region at the end of 2012. Estimated adult HIV prevalence varies from below 0.2% in part of Central Europe to around 0.7% in parts of Easter Europe. In 2011, a total of 3905, 2997 and 24773 new HIV infections had been diagnosed in Western, Central and Eastern Europe respectively (WHO/UNAIDS/UNICEF, 2011).

Among Western European countries; Belgium (10.7) and the United Kingdom (10.0) had reported the highest rates of HIV infections in 2010 and highest rates of AIDS diagnoses were in Portugal (2.8 per 100,000 population) and Spain (1.8). Among Eastern Europe countries; Ukraine (38.0 per 100,000) and Moldova (20.3) recorded the high rate of HIV infections in 2011. In Central Europe, Romania (1.3 per 100,000) has reported the highest rate of HIV infections in 2011. Heterosexual root is the primary root of transmission in almost all the European countries (UNAIDS, 2012c; WHO, 2010; WHO/UNAIDS/UNICEF, 2011).

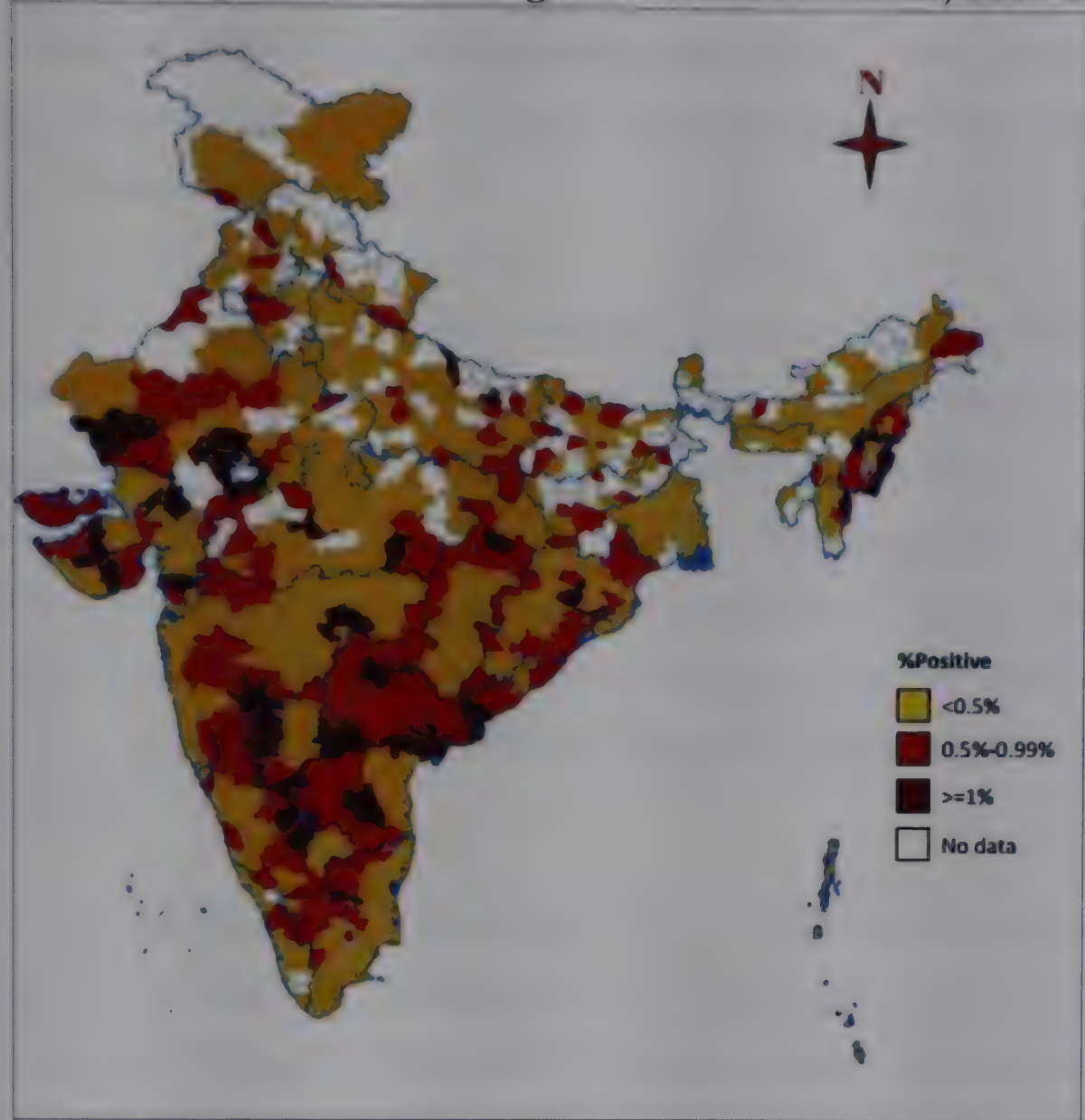
With an adult HIV prevalence of 0.2%, the number of people living with HIV in this region reached an estimated 51,000 at the end of 2012 (WHO/UNAIDS/UNICEF, 2011). There are about 2100 new HIV infections detected in 2012, and the number of people dying from AIDS-related cause decreased considerably falling to 1200 in 2012, as compared to the annual figure of about 2400 in 2005-2007. Unprotected heterosexual intercourse is the primary mode of transmission in most of the region including Papua New Guinea, whereas unprotected sex between men plays a larger role in the epidemics in Micronesia, Polynesia, Australia and New Zealand. Injecting drug use plays a minor role in the epidemics in this region (Group, 2010; STI HIV and AIDS Surveillance Unit, 2009).

Almost all the 22 Pacific island countries and territories are experiencing minuscule HIV epidemics since 1985. But Papua New Guinea is an exception that has the largest and the only generalized HIV epidemic in Oceania (Community, 2010). The national HIV prevalence among adults in Papua New Guinea in 2009 was an estimated 0.9% with about 34000 people living with HIV. Other than this, Australia has the stable epidemic at about 1000 cases since 2005 and New Zealand reported an about 180 new infections in 2005-06 (Group, 2010; University of New South Wales, 2010).

2.2.4 HIV epidemic in India:

India has the third highest HIV epidemic in the world with an adult HIV prevalence of 0.29% as of 2014 (NACO, 2013). The overall HIV prevalence in India looks small, about many other middle-income countries, but because of India's huge population (1.2billion) this equates to 2.39 million people living with HIV (NACO, 2013-14). Children (<15yrs) account for 7% of all infections while 86% people living with HIV (PLHIV) were in the age group of 15-49 years. Of all HIV infections, 39% (0.8 million) were among women (NACO).

Figure 1: HIV prevalence among ANC clinic attendees, 2010-11



Source: HIV sentinel surveillance-Technical brief 2010-11, National AIDS Control Organization.

HIV prevalence in India varies geographically. Much of India has a low rate of infection, although certain places have been more affected than others. Earlier, HIV epidemic was more severe in the southern half of the country as compared to far north-east. But the most recent annual sentinel surveillance shows that HIV epidemics are more severe in the north-eastern states, compared to the south India states. The highest estimated adult HIV prevalence is found in Nagaland (1.29%), Mizoram (0.89%) and Manipur (0.60%). Whereas it is declining in South India states, mainly undivided Andhra Pradesh (1.45% in 2003 to 0.35% in 2014-15), Karnataka (1.43% in 2003 to 0.36% in 2014-15), Maharashtra (1.15% in 2003 to 0.32% in 2014-15, and Tamil Nadu (0.83% in 2003 to 0.27% in 2014-15) (NACO, 2007,

2012-13, 2013-14, 2014-15). In the north-east state like Manipur, HIV is primarily spread through injecting drug users and whereas in southern states, the infection spread primarily through heterosexual contact (NACO, 2014-15).

HIV epidemic in India has more concentrated among different high-risk groups. According to NACO 2010-11 sentinel surveillance, Transgender (8.82%) IDU (7.14), MSM (4.43%) and FSW (2.67%) has more HIV prevalence compared to ANC clinic attendees (0.40%), which considered as a proxy for general population. Migrant workers (0.99%) and truckers (2.59%) also viewed at higher risk groups, as potential bridge populations between high-risk groups and the general population.

HIV epidemic in India shows a clear declining trend in recent years. The overall HIV prevalence has declined from 0.45% in 2002 to 0.36% in 2006 and 0.3% in 2011. The total number of people living with HIV also declined from 2.73 million in 2002 to 2.47 million in 2006 and 2.1 million in 2011. Also, India has demonstrated an overall reduction of 57% in estimated annual new HIV infections (among adult population) during the last decade from 2.74 lakhs in 2000 to 1.16 lakhs in 2011. Despite this reduction in overall prevalence, the percentage of females among PLHAs has remained around 39%. There is little difference in HIV prevalence in urban versus rural settings, and HIV prevalence decreases with increasing educational levels and is highest among women whose spouses work in the transport industry. However, there seems to be heterogeneity in the regional HIV prevalence (NACO, 2013-14). Recently held National AIDS Control Programme Phase-IV multi-stakeholder meeting identified that emerging epidemics due to migration might be one of the fundamental challenges for NACP-IV. Migration for work takes

people away from the social environment of their families and community. This can lead to an increased likelihood to engage in risky behaviour. Concerted efforts are needed to address the vulnerabilities of the large migrant population. Furthermore, a high proportion of female sex workers in India is mobile. The mobility of sex workers is likely an important factor contributing to HIV transmission by connecting high-risk sexual networks (NACO, 2012-13, 2013-14).

2.2.5 HIV epidemic in Karnataka

As mentioned earlier, Karnataka is one among the high HIV prevalence states in South India and ranks 2nd after Andhra Pradesh. As per 2011 HIV sentinel surveillance, adult HIV prevalence in Karnataka is 0.69% and this is more than double to the countries overall HIV prevalence. As per recent estimation, there are about 2,09,368 people are living with HIV in Karnataka and among them, 6% are children less than 15 years and 40% are female. As of 2011, an estimated number of annual new HIV infections are 14992, an estimated number of annual AIDS-related deaths are 16989, and an estimated number of people need ART treatment was 105784. HIV epidemic in the state is not a generalized epidemic; rather it is more concentrated among the high-risk population. HIV prevalence among FSWs (5.10%) and MSM (5.36%) in the state is quite higher than the general population and transmission is largely through the route of sexual relationships and networks especially among the high-risk groups.

HIV prevalence in the state varies substantially across the district, ranging from just over zero in some districts to upward of 3% in other (Becker et al., 2007). As per more recent estimation, 11 districts in the state has more than 1% of HIV prevalence among ANC attendees and those districts includes Bagalkot, Belagavi, Bellary, Vijayapura, Chamrajnagar, Davangere, Dharwad, Gadag, Hassan,

Kodagu and Tumkur (NACO, 2012-13). The epidemic in the state also shows a highly heterogeneous and an enormous variation found between the districts in north and south Karnataka.

The high prevalence districts found in the northern regions comprise of 3 districts namely, Belagavi, Bagalkot and Vijayapura. Data from sentinel surveillance with antenatal clinic attendees and a population-based survey indicate that HIV prevalence has exceeded 3%, with those living in these three districts in the past several years. The reasons for this epidemic pattern in these three regions are not well understood. However, HIV program assessments and ecological studies suggest that in the Belagavi, Bagalkot and Vijayapura district HIV prevalence at the taluka level is correlated with a relatively high proportion of men reporting visits to FSWs and a high per capita number of FSWs about other regions in the state. Besides this, there are two additional pertinent features of sex work in this region. First, the *Devadasi* system of 'dedicating' girls to a life of sex work in the name of religion is embedded in the social and cultural life; many of the FSWs live and practice sex work in these areas. Second, over several generations, a pattern has developed whereby FSWs from villages in northern Karnataka migrate to work in brothels in the large cities of Mumbai and Pune in Maharashtra, and smaller and closer towns and cities just to the north of the state boundary. This 'migration' factor has likely had a significant influence on the HIV transmission dynamics in the region since the HIV epidemic in cities such as Mumbai and Pune appears to be in a more advanced stage than elsewhere. By inference, the large-scale movement of FSWs between the towns and the more rural areas of southern Maharashtra and northern Karnataka may have provided a possible "bridge" for HIV transmission back to the Belagavi, Bagalkot and Vijayapura districts and other rural areas.

2.3 Sex work

2.3.1 Sex work definitions

The term 'sex worker' is being widely used as a substitute for 'prostitute' mainly on the ground that those engaged in prostitution are providing a service to workers in other professions (Nag, 2006). According to Ellis, a sex worker is not a commodity with a market price and to speak of her selling herself is both inexact and unjust. He further states that when an act of prostitution thus put on an individual basis, it is not utterly degrading, although it does not thereby 'become conducive to the best development of either the sex worker or her client' (Ellis, 1917; A. Ellis, 1959).

The idea of prostitution as a kind of service has become popular from the 1980s onwards, with an intention to mobilize these women for HIV prevention interventions. In 2002, UNAIDS said, the term 'sex worker' has gained popularity over 'prostitute' because those involved in prostitution feel the reference to 'work' better describes the services they provide to their clients (UNAIDS, 2002). In the most current literature on prostitution, the term 'sex worker' is used instead of 'prostitute', but the use of the term 'sex work' or 'sex trade' as a substitute for the term 'prostitution' is not so common as yet (Nag, 2001a, 2006).

In my thesis, the term 'sex worker' or 'female sex worker' (FSWs), is used as a substitute for a prostitute, but in this section, the term 'prostitution' is retained to denote the profession of sex workers. The word prostitution means "the offering of the body to indiscriminate lewdness for hire (Oxford English Dictionary, 1909). According to International Encyclopedia of Social Sciences, "granting of sexual access on a relatively indiscriminate basis for payment, either in money or in goods and this always depends on the

complexity of the local economic system. Payment is acknowledged to be for a specific sexual performance” (David, 1968).

Jeremy Sandford in his book ‘prostitutes’ defines; prostitution is sex for sale or barter but not given. There is a transaction, and the sale of sex is its sole or primary purpose (Sandford, 1975). Moninag in his book ‘Sex worker of India’ argues that the term sex work or prostitution vary in their context according to variation in the practice of prostitution in different age and different socio-cultural setting. According to him, following three elements should present to define the prostitution; 1. Payment of money or goods in exchange for sexual service offered by one person to another, 2. Promiscuity on the part of the person offering the services and 3. Emotional indifference on the part of both service provider and service receiver (Nag, 2006).

In general, sex work or prostitution is a kind of service performed by males, females or transsexual people, who offer sexual service to some persons of the same or another gender in exchange for money or goods.

2.3.2 Historical perspectives on sex work in India:

Sex work is an age-old institution and a review of the literature on prostitution in classical India reveals that early Indian attitude to prostitution was that, it was a necessary element in the organization of the society. Anecdotal evidence suggests that the prostitution in India can trace back to archeological findings of the Indus Valley (Singh, 1997). The bronze figure of dancing girl from Mohenjodaro represents a sacred prostitute carrying out her duties within the precincts of the temple of some mother goddess, and this cult quite well established in the Indus Valley civilization (Leela Sampige, 2004; Singh, 1997).

There are references to prostitution in a Vedic literature known as 'Brahmanas' (8th to 5th century B.C.) (Joardar, 1984). The cult of 'chastity' (The state of not having sex with anyone or only having sex with the person you are married) in marriage during Brahmanic period forced particular section of the women to take up prostitution as a profession. These include 1. Neglect and abuse by husband and in-laws, 2. Inability to find a suitable husband belonging to an appropriate cast before attaining puberty, 3. Widowhood and the consequent abuse by in-laws, 4. Social stigma as a result of abduction or civil violation and 5. The custom of giving away of girls as gifts in religious or secular events (Nag, 2001a, 2006). The prostitutes of this Brahmana period known as '*vaishya*' (Basu and Sinha, 1929).

There is a frequent reference to prostitution in the sacred books of Hindu religion including the Ramayana, the Mahabharata, and the Smritis or Samhitas (Basu and Sinha, 1929). The presence of courtesan (sex worker with high qualification) was considered as an essential feature of any celebrations (Joardar, 1984)). Kings, when they returned from war or journey, was expected to receive by an escort of honor consisting of armies and courtesans. There are references to the presence of prostitutes during the war of the Mahabharata. After the victory in war, Raja Virata ordered the beautiful courtesan to sing in accompaniment with musical instruments. Also, marriage with a prostitute was not looked down upon at this age (Basu and Sinha, 1929; Joardar, 1984). The king Puruba of Prayaga (Allahabad) married 'Urvashi' the celestial courtesan. Their son became King after Puruba (Brahma Purana, Chapter x). It was also well known that great sage 'Vasistha' was the son of a prostitute (Joardar, 1984). There are also many references in Indian mythology about the celestial courtesans like Urvashi, Ramba, Menaka, Misrakeshi, Gritochi, Thilothamma and that they would

dance before the king of heaven (Jaishankar and Haldar, 1997; Joardar, 1984).

According to 'Jatakas', a collection of folk tales related to Gautam Buddha (640-560 BC), low-level sex worker during this period led an extremely unpleasant and disgusting life (Young, 2004). But despite this, there are some references about the courtesan who are famous and beautiful, namely; 'Addakasi', 'Ambapali', 'Sirima', 'Sulasa', 'Bindumati', 'Sama' and 'Padmavati'. Most of them accommodated in the royal palace, highly paid and occupied a recognized position in the social scale (Joardar, 1984; Tyagi-Delhi, 1987). At the later stage, most of this courtesan were inspired by Gautama Budha and some of them learned the philosophy of Buddhism and became a learned nun (Gopalakrishnan V.S., 2012; Young, 2004). Jainism also existed during the same age, and it looked down upon prostitution. According to Jain sources, prostitution was so rampant in the country that Jain nuns were cautioned against it (Leela Sampige, 2004; Singh, 1997).

The Greek diplomat Megasthenes visited Chandra Gupta Maurya's Kingdom around 324-300 B.C. and delineated the existence of prostitutes (Bhattacharji, 1987). During his era, prostitutes played a role as infiltrators of enemy armies, security force for the king and testers of any food, garments, flowers, ornaments or scents to be used by the king. These responsibilities reflect the importance of prostitutes in political and national affairs of the kingdom (Henriques, 1962; Joardar, 1984). Maurya period saw an appreciable change in the status of sex worker and Pataliputra remained the flourishing center of prostitution, because of its effective control and obligation of a stabilized taxation system (Bhattacharji, 1987; Nag, 2006).

The 'Arthashastra' written by Vishnugupta, commonly known as 'Kautilya' between 321 and 296 B.C (Subramanian V.K., 1980) is an ancient Indian treatise on statecraft, economic policy, and military strategies. Kautilya Arthashastra consists of 15 volumes, and it written in Sanskrit (Joardar, 1984; Subramanian V.K., 1980). The 27th chapter of the second book describes the duties of the '*Ganikaadkshya*' (superintendent of prostitutes), and this is one of the earliest footprints about the life of prostitutes in ancient India (Basu and Sinha, 1929; Joardar, 1984). Kautilya used an array of terms, including the word '*ganika*' for prostitutes and defined their role and responsibilities (Henriques, 1962). These women trained in singing, dancing, acting, music, soothsaying and the making scents and garlands, and they received a high-quality education that paid for by the state. The state had its control over the ganika's and used them as a source of revenue for the state. Ganikas had to pay a tax amounting to one-sixth of their income. State extended substantial support to the young beautiful and talented women to setting up an establishment of ganikas and every ganika living in an establishment was required to report to its head. The head of an establishment was required to submit an account to the Chief Controller of Entertainment. Like this, a code of conduct was prescribed to ganikas and the people seeking their favors. Prerogative rights and duties defined to ganikas show the importance of the social position of ganikas during this period (Bhattacharji, 1987; Joardar, 1984; Nag, 2006; Saxena, 2006; Shamasastri, 1967).

Another important testimony for the sex work in the ancient Indian setting is the Kamasutra (Joardar, 1984). The Kamasutra is an ancient Hindu book on the art of living about sexual satisfying life. It was written between 2nd and 4th centuries A.D. (Burton R.F., 1991; Doniger, 2003). Vatsynana's Kamasutra has 1250 verses, distributed in 36 chapters, which further organized into seven books. Book six

talks about courtesans or sex workers and it cover issues such as advice of assistants on the choice of lovers, looking for a steady partner, different ways of making money, reunion with a former partner, various types of gain and losses (Burton R.F., 1991). The narratives in Kamasutra books six include mostly the behavioral and attitudinal characteristics of the ganikas and their clients as well as instructions for both (Nag, 2006). Chapter one explains the characteristic of ganika's and an ideal ganika should possess of beauty and amiability with auspicious body marks. She should have a liking for good qualities in other people as also a fondness for wealth. She should take delight in sexual unions, resulting from love and should be of a sound mind. Also, she should have qualities such as intelligence, good character, good behavior, honesty, gratitude, etc. She should be free from depression, excessive laughter, malignant gossip, verbal abuse, greed, dullness, and fickleness. She should also be skilled in the Kamasutra and its ancillary sciences (Burton R.F., 1991; Joardar, 1984; Nag, 2006). Chapter two explains the duties of ganika and says ganika should like to live as a wife of her lover. It is her duty to respect and give him pleasure. It also means ganikas should not become attached to him, though behaving as if she were attached (Burton R.F., 1991; Saxena, 2006). Chapter three describes the ways of extracting money from the client through lawful means or artifices ways. Chapter four describes reunion with a former lover. When a ganika abandons her current lover, after all, his wealth exhausted, she may then consider about her reunion with a former lover and this she considers if he has acquired fresh wealth or is still wealthy and if he is still attached to her (Burton R.F., 1991; Joardar, 1984). Chapter five says, if ganika can get more clients a day, she should not confine herself to a single lover and in such circumstances, she should establish her price for a night taking into account the place, time and conditions and her other women (Burton R.F., 1991). Also, she can

inform her lovers, friends and acquaintances about these changes (Nag, 2006). Chapter six is all about gains and losses; if a ganika desires to keep clients from going elsewhere or if she wants to get money away from some other ganika, she should improve her position, prosperity, future, and her sex appeal. It has also recommended the richest ganikas to build temples, pools, and gardens, etc. (Bhattacharji, 1987; Burton R.F., 1991; Leela Sampige, 2004; Nag, 2006)

Sex workers maintained prominent social position within Indian society during the Gupta age (300 A.D. – 500 A.D). They engaged in dancing, singing and worshipping in the temples like Mahakala at Ujain. During the Chandragupta Maurya period, prostitution was brought under the control of government and rules and regulations were framed for the better administration of brothels. Accordingly, the king appointed a superintendent of prostitutes on a salary of 1000 panas per year, whose duty was to control the prostitutes. The earnings of the latter were taxable, and they were also encouraged to learn the art of music and dancing to be able to entertain customers (Joardar, 1984; Sundara Raj, 1993).

During the period of Chalukyas of Badami (6th century A.D to 8th Century A.D), Karnataka found the references of courtesan namely; 'vinopoti' and 'Badipoddi." Badami Chalukyas have given a generous donation to the Mahakoota temple including; golden seat, silver umbrella, land of 800 measures, a horse chariot, elephant, etc. Also, these women did not think that it was beneath their dignity to call themselves courtesans (Joardar, 1984; Nag, 2006). These periods also played a significant role in emergence and development of *Devadasi* system, and there is an in-depth discussion carried out in the next section.

Narratives from Persia's Ambassador Abd-Er-Razzak, who visited Vijayanagar Kingdom in 1442 A.D, provide evidence of prostitutes in the city M. These evidence that prostitutes used to give sexual pleasure to the army and so that, a considerable amount of their pay might have reached the prostitutes. Abd-Er-Razzak in his travelogue explains that beautiful courtesans sat in the king street, and each one of them wore the gorgeous garment, bedecked with pearls and gems of great value. Any man has an open permission into this locality and can select any girl who pleases him and takes his pleasure with her. Courtesans and dancing girls are privileged to a special status during the celebration of Mahanavami festival in the Vijayanagar Kingdom (Joardar, 1984; Nag, 2006).

Prostitutes and their profession flourished under the royal patronage of Mughal empires of India around 1000 A.D, But the Mughal empire Aurangzeb (1658-1707 A.D) and Akbar (1556-1605 A.D,) was exceptional for this (John-Fisk, 2013). Aurangzeb was a committed Muslim puritan and did not tolerate the harmful influence of the prostitutes in his tenure. He directed toward the prohibition of prostitution, and he ordered prostitutes to marry or leave the empire. Due to his order, some of the prostitutes married and other went away or concealed themselves (Jaishankar and Halidar, 1997). As compared to Aurangzeb, Emperor Akbar was concerned about prostitution. During his tenure, he made certain regulations of course not to abolish prostitution, but to impose a particular restriction upon it. His directives forced prostitutes to live together outside of the capital city, and this place called as 'shaitanpura' or the devils quarters (Joardar, 1984). Kings administration appointed a supervisor and his assistant called 'Dorgoha' and 'clerk' to supervise the activity at shaitanpura and men were not allowed to take dancing girls to his house without the permission of these supervisors (Nag, 2006). In the later days,

prostitutes received sufficient encouragement by succeeding emperors and intensified their activities. Sahajahan's son 'Dara Shikoh' married a courtesan named 'Ra No-Dil' and given the same status and honor as other Mugal princess enjoyed (Manucci & Irvine, 1965). The writings of 'Malik Muhammad Jayasi' from Afghan indicates that prostitutes used to play veena with such a skill that people were completely overwhelmed and lost sense whenever they might have listened to the performance. But after the downfall of the Mugal Empire, most of the courtesan came out of the royal palace and faced difficult time (Jaishankar and Haldar, 1997; Joardar, 1984; Saxena, 2006).

2.3.3 Sex work in colonial India:

Colonial India is a part of the Indian subcontinent that was under the control of European colonial power through trade and conquest (Mill, 1858). The colonial India was largely ruled by British East India Company from 1858 to 1947 (Oxford English Dictionary, 2008). Sex trade was not a new phenomenon in colonial India, but colonialism made a significant impact on sex work by institutionalizing the sex trade. The new form of sex work during colonial India was directly imposed by material circumstances (Levine, 2004).

During the late 18th century, British East India Company concentrated their trade in Bombay (Mumbai), Madras (Chennai), and Calcutta (Kolkatta) for the reason that these provinces had an abundant supply of cotton for textiles. These provinces were also famous port towns, and it was common that some sailors of foreign ships halting in these port cities (Kaminsky, 1979). British East India Company deployed a large number of military force in these settlements with an intention to take over the country. The British military force in India composed of both European and native

contingents and had an average annual troop strength of roughly 2, 00,000 men (Kaminsky, 1979). The majority of these British soldiers were aged less than 30 years, and most of them were unmarried and those who were married had left their wives at home (Roy, 1998). The presence of soldiers, sailors, and migrants in the town made it a well-situated place for the sex workers (Nag, 2006). The British soldiers visiting sex workers resulted in high prevalence of sexually transmitted diseases (STDs) among them (Levine, 2004). Data analysis of soldiers infected with STDs over a five-year period in 1830 showed a rate of 32 to 35 percent of the prevalence of STDs among British soldiers compared to 2 to 3 percent among their Indian counterparts (Nag, 2006). Another study indicates that annual admission of British troops to the hospital for venereal infections, predominantly Syphilis and Gonorrhea was over 200 per 1000 by 1895, and this reached over 500 per 1000 at the later stage (Arnold D, 1993; Roy, 1998).

The increased number of STDs among British soldiers had encouraged the military administration to regulate the sex work in colonial India. The British military administration was very much concerned about the physical well-being of their military soldiers because, they had the challenge to suppress the periodic rebellions of the Indian masses at that time. The military administration decided to solve the problem of high rate of STDs among soldiers by promulgating 1864 Cantonment Act. The act not only permitted but promoted the European troops to hold native young and good looking girls as prostitutes for their carnal pleasure (Bhandari, 2010; Levine, 1996; Nag, 2006; Roy, 1998).

According to 1864 Cantonment Act, British army authorities set up brothel known as 'chaklas,' in the regimental shopping areas and other appointed places within the cantonments. The chaklas

supervised by 'mahaldaranis' appointed by the government. Mahaldarnis could be male or female, and they are usually hereditary sex workers. They were responsible for the women's management, filling up the vacancies in their ranks and taking them to a physician for periodical examination. They were also required to act as pimps and provide women for the use of soldiers at their request of their commanding officers. The British authorities established some specialized hospitals called 'Lock Hospitals' for monitoring and treating STDs among both the sex workers and the soldiers (Bhandari, 2010; Levine, 1994, 2004; Nag, 2006; Roy, 1998).

The 1864 Cantonment Act to prevent STDs among British soldiers did not succeed because, the soldiers often tended to move out of their cantonments due to a paucity of sex workers in the regimental chaklas or because of troops movements. So the sexually transmitted infections remained increased among soldiers because they had sexual intercourse with sex workers outside the cantonment (Chang, 2007; Legg, 2012; Nag, 2006).

To control the sex workers operating their trade outside the cantonment area, the colonial authorities in India enacted the Indian Act in 1868 (Chang, 2007; Willcox, 1961). The Contagious Disease Act sought to prevent venereal diseases in military personnel through several regulations. The act required the registration of women engaged in sex work and these women were often required to carry a license in the form of a card. In some areas, cantonment magistrates brought pressure on women practicing sex trade outside the cantonment to leave their places to move into chaklas. Registered prostitutes in chaklas were called 'Lal Kurti' (Queens Ladies) (Bhandari, 2010; Willcox, 1961). This act mandated the regular medical examination of female prostitutes. If any prostitutes practicing in chaklas were found to infect during an examination, they

were required to undergo in-patient treatment. In case, they refused such treatment, they could be penalized by imprisonment. Once cured of their disease, they were released. Interestingly, none of these measures were applied to British soldiers. The act was solely targeted female prostitutes as they were the only people subject to licensing and medical examination (Legg, 2009; Levine, 1994).

The Contagious Disease Act was controversial from the time it had enacted, and it was considered as a failure because the measures directed at only one sex. This act has been severely affected sex workers business by driving away their regular customers, who were put off by the sudden police raids. As a result of public agitation, particularly from women's groups in Britain, the Indian Contagious Disease Acts were repealed in 1888. Registration and licensing of prostitutes, the old rigid lock hospital system and even the hospitals themselves were abandoned (Ashwini Tambe, 2009; Bhandari, 2010).

Another important feature of prostitution in Colonial India was an import of European prostitutes to India (Ashwini Tambe, 2009). In the 19th and early 20th centuries, thousands of women and girls from continental Europe were trafficked into British India, where they worked as prostitutes serving British soldiers. In most cases, European prostitutes were considered as poor whites or poor Europeans, indicating their perceived low socio-economic status (Fischer-Tine, 2003). Most of the European prostitutes in British India were recruited from Serbia, Romania, Greek, Russia, Poles, Japan and Southern Russia. Interestingly, most of them were either Roman Catholics or Jewish and only very few are the English women among them. British authorities were more concerned about the mixed race children from native males and white women and they perceived that this type of interaction could undermine the colonial hierarchies based on class and race (Tambe, 2005). Ashwini Thambe in her study of European

Prostitution in Colonial Bombay argues on intermediary status, granting them an unusually complicated position as privileged subalterns in British India (Ashwini Tambe, 2009).

Literature provides a clear indication that, the purpose of the British regulated prostitution through mandatory licensing and medical examinations were not out of concerns for prostitutes, but out of concern for their military men.

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2.3.4 Sex work in the contemporary India:

Sex work continued from ancient and medieval India and had taken a more substantial position in the modern India. The modern face of sex work in India is a sad story of women forced to become sex worker due to economic deprivation, betrayal by their spouses/lovers/families, certain social customs and even reasons such as incest and rape. There are multiple reasons why women in India pushed into sex work. Most important reasons include low educational levels, poverty, famine, low caste, being widowed, separated or divorced, trafficking, migration and peer pressure among others (Becker et al., 2007; Chattopadhyay & McKaig, 2004; O'Neil et al., 2004). Modern India's legal regime on sex work is laid down under Immoral Traffic Prevention Act 1956 (Known as ITPA) (V. Sithannan, 2006). As per the act, sex work per se is not illegal but penalizes specific activities related to commercial sex. According to law, brothel keeping, living on earning of sex work, procuring, inducing or detaining for prostitution, prostitution in areas notified by police and near public places and soliciting could be penalized (V. Sithannan, 2006).

Modern sex work has changed its form and despite the law, the total number of women practicing sex work has been extensively increased in most recent days. According to the recent estimation by

National AIDS Control Organization, of India, there are about 830,000 to 1.24 million female sex workers in India with considerable variations among states (Blanchard, Moses, et al., 2007; NACO, 2006, 2013). As per recent estimation by the ministry of health and family welfare of Government of India, Andhra Pradesh, Karnataka, Tamil Nadu, Maharashtra and West Bengal consist most number of female sex workers (NACO, 2006, 2013). There are more than 100,000 women practicing sex work as identified in Mumbai only and Kamatipur in Mumbai has been considered as Asia's largest red-light area (NACO, 2006; Nag, 2006; S. D. Puneekar. Kamala, 1967).

Women practicing sex work in modern India has categorized into five main typologies based on where they work and more specifically on where they recruit or solicit clients and not where they live or entertain the clients. The major typologies of female sex workers in India Includes: home based (entertaining clients at home), brothel-based (entertaining clients at brothel which is usually maintained by a madam who is called a Gharwali), street based (solicit clients in the street and entertain the clients at a small room in the village or nearby place), lodge based (entertain clients at a lodge) and Dhaba (roadside restaurants in the highways) based sex work (Buzdugan, Halli, & Cowan, 2009; Buzdugan et al., 2012; NACO, 2007). This classification was made mainly in the context of HIV/AIDS and apart from this, there is also an elite group of the sex industry in India. This group includes escorts or call girls who are educated college girls or girls from glamorous industries like modeling and film industry. They usually advertise their services through more high-tech methods such as the Internet and even advertising in newspapers. This elite group of women enters into the world's oldest profession willingly and knowingly (Leela Sampige, 2004; Nag, 2001a).

More specific to Karnataka, the current estimate (2009-2010) of the total number of women in sex work in Karnataka is 134,691 of which 72,032 are in the rural areas while 62,929 in urban areas. Of the total sex workers in the urban areas 50% sex workers are street-based sex workers while little more than half of the sex workers (54%) in rural areas are home based (Isac, 2013; KSAPS, 2014). A study conducted by Population Research Center (PRC) Dharwad and India-Canada Collaborative HIV/AIDS Project (ICHAP) have identified the differences in the characteristics of women practicing sex work in different parts of Karnataka (ICHAP, 2003; B.M. Ramesh, Rajeshwari, & Sankangoudar, 2003). According to this study, the majority of sex workers (66%) in Northern Karnataka work either at home (45%) or in brothels (21%) while the majority (75%) in Southern Karnataka, work in public places. Female sex workers in North Karnataka on an average begin working in commercial sex five years earlier than FSWs from southern Karnataka: 73% of sex workers initiated sex work when they were 19 years or younger compared to 34% in the south Karnataka. In northern Karnataka, 49% of FSWs cited *Devadasi* tradition as the leading reason to enter sex work followed by poverty/needing extra money, while 58% of FSWs in southern Karnataka cited poverty/needing extra money as the main reason to start sex work. Northern Karnataka sex workers are three years younger on average compared to southern Karnataka sex workers and the majority (70%) of sex workers in northern Karnataka are unmarried (including those who were cohabiting with a partner) compared to only 19% of sex workers in southern Karnataka. Also, more FSWs in northern Karnataka belong to scheduled castes, and a higher proportion of FSWs in the north Karnataka are illiterate (89%) compared to southern Karnataka (71%). The study also identified the migration of female sex workers in the north Karnataka and recommended to conduct a comprehensive research to better

understand the migration patterns among sex workers in the north Karnataka (ICHAP, 2003; Leela Sampige, 2004; B.M. Ramesh et al., 2003).

2.3.4 The *Devadasi* tradition:

The word '*Devadasi*' is derived from the Sanskrit word '*deva*' means 'God' and '*dasi*' means, 'female servant' (Goswami, 2000; Shankar, 1990). The *Devadasi* tradition was originated between the 3rd and 6th Century A.D. throughout India (T.R Orchard, 2007). *Devadasis* were women, dedicated to marriage to different Gods and Goddess, and were supposed to attend various temple duties including cleaning the temples, decorating deities, singing devotional songs and performing sacred arts in festivals or important ceremonies (Kersenboom, 1987; O'Neil et al., 2004; Tarachand, 1991). The art of dance meant for entertaining the Gods and took place in front of the image of the Lord. However, as time passed, *Devadasis* were made responsible for providing sexual services to priests and patrons of the temple and to owe to the sacred setting and the view that *Devadasi* women embody a form of divinity. This activity has been referred to by some as 'sacred prostitution (Anil Chawla, 2002; Blanchard et al., 2005; Leela Sampige, 2004; O'Neil et al., 2004).

The *Devadasi* cult has been prevalent in mainly, South Indian states namely; Karnataka, Maharashtra, and Andhra Pradesh with minor variation in customs and terminology associated with it (Nag, 2006). The tradition has known by different names in different places, such as 'Basavi,' 'Jogati,' 'Jogini,' 'Kasabi,' 'Sooli' and Muttakattikondavalu in Karnataka. 'Bogam,' 'Dogma,' Matangi,' 'Saul,' 'Venkatasini', and 'Sani' in Andhra Pradesh. 'Thevardiyar,' 'Teraradiyll', and 'Dasil' in Tamilnadu. 'Kudikkar' and 'Maheri' in Kerala and 'Andhini,' 'Jogati,' 'Jogin,' 'Jogtini,' 'Murali' and

‘Venkatasani’ in Maharashtra. ‘Bhavani,’ ‘Derli,’ ‘Jogati,’ ‘Naikin,’ and ‘Vevin’ in Goa (Nag, 2006; Shankar, 1990).

Devadasis commonly dedicated to the goddess Yellamma-Renuka in South India, and there are many references about Renuka Yellamma in Hindu mythologies including, Mahabharata, Brahmandapurana, Visnupurana, Skandapurana and Renuka Purana (Arun Jaganathan, 2013). According to one popular story, Renuka, consort of sage Jamadagni was a pure/chaste woman. She was so pure that she could carry water in a freshly molded pot. She would mold one pot every day on the banks of the river where she went to fetch water. On one of these trips, she happened to see a Gandharva couple bathing in the river. She was struck by the handsome looks of the male partner as she saw his reflection in the river water. However, because of this alleged violation of her marital vows, the pot broke, and, her husband caught her in this act of adultery. He decided that she had sinned by coveting a man who was not her husband. Angered by this, Jamadagni ordered his 12-year-old son Parasurama to behead his mother. When Parasurama was going towards the forest to cut his mother head, a low caste woman namely ‘Matangi’ came and tried to help Renuka. Parasurama attempted to avoid Matangi and unable to do so. Parasurama gave a severe blow with his axe and by mistake, both the women head got cut. Happy with his son’s unquestioned obedience, Jamadagni wished to bless him with a boon. The clever son Parasurama requested his father to bring his mother back to life. Jamadagni considered his son request and gave him a holy water and suggested to sprinkle the water when his mother head was fixed to the body of the dead one. Parasurama reached near his mother's corpse and in a hurry, he joined the heads wrongly, i.e. his mother's head onto the body of that other woman and the other woman’s head onto the body of his mother and they both got rejuvenated. Later people started

worshiping both the women as a goddess and one with the head of Renuka was named as Mariamma and other one came to know as Yellamma (Anil Chawla, 2002; Arun Jaganathan, 2013; Nag, 2006). Young girls of low castes were after that dedicated to the goddess Yellamma-Renuka in the belief that they would wed to Parsurama, the devoted son of Renuka. Another belief is that lower caste woman "Matangi" achieved the higher status of being a Brahmin's wife has encouraged the number of young girls of the lower caste to dedicated to the goddess Yellamma. Like this, there are many myths about Renuka-Yellamma and the reason behind dedicating lower caste girls to these deities. However, when time passed, girls were also devoted to male deities representing Hanuman, Ganesha, Jamadagni, and Parsurama (Leela Sampige, 2004; Nag, 2006) and this varies from place to place.

The *Devadasi* dedication ceremony is more or less similar to the ceremony of marriage and it slightly varies from place to place, depending on the deity to whom they are dedicating (Nag, 2006). Joghnan Shankar in his book, *Devadasi Cult: A Sociological Analysis* described the customs and process involved in *Devadasi* dedication ceremony. According to him, the dedication ceremony is called 'Muttu Kattuvadu' (tying the beads) or 'Devarige Biduvadu' (dedicating to the deity) in the local language. The auspicious days for dedication are full moon days that come in the month of March-April and November-December of every year. Also, in particularly the full moon days which comes on Tuesday or Fridays are considered as more auspicious since these days are considered the days to worship female deities. On such days, the dedication may be conducted in Yellamma temple Soudatti, a local temple in the village or their house. In recent days, dedications are not performed in either Yellamma temple Soudatti or any other public places due to the legal

complications. The dedication ceremonies were performed by senior *Devadasis* (*Jogati*) in the presence of girl's family members and few selected relatives. Worshiping materials used in the ceremony include Kumkuma and Bhandar (Vermilion and turmeric powder), plants, betel leaves, sandal paste, ceremonial ash and *muttu* (beads) with tali (Mangalasutra) or without. The senior *Devadasis* present sings a chorus in praise of Yellamma accompanied by *Chowdaki*, *Tamboori*, and *Jagate* (Traditional Musical Instruments). After girl's family consent, priest or the senior *Devadasi* tie the bead necklace to the girl's neck by chanting "Udho Yellamma, Udho Jogaldo, Udho Yekkeldo" and keep a Jaga (begging bowl made of bamboo cane) on the head of the girl. The dedication ceremony will end after the first begging of the newly dedicated *Devadasi*. The next step is the *Uditumbuvadu* or Deflowering Ceremony, which not concerned in any way with the deity she has devoted to. Locally, this ceremony is also called as "*seragu hidisodu*" and it happens after girl attains puberty. Earlier, the priest of the local temple enjoyed the right of deflowering *Devadasis* after attaining puberty, and now it is the local landlords or businessmen or other wells to do people from the same or nearby villages who deflower the girl. These people may approach *Devadasi* girl's parents directly or through the senior *Devadasi* and before deflowering ceremony an agreement made towards the payment and provision of subsistence, ornaments, and dress to be provided to the girl. The patrons who deflower the girl have more priority, but they cannot bar the girl from entertaining other clients (Shankar, 1990).

The custom of dedicating girls to Yellamma and the temples of the Goddess traced back to the 3rd Century. *Devadasis* at that time worked in temples as entertainers. They sang and danced at temple functions and religious festivals. They considered as custodians of culture and the arts such as music and dance. They bestowed with

grand gifts of land, property and jewelry by royal patrons and so most of the *Devadasis* in the past were quite wealthy. There are many references to the devadasi's association with temples in the Indian history. Tanjore temple dated 1004 AD show that there were 400 *Devadasis* attached to it. There are also references to 4000 temples in Gujarat reported to have about 20000 *Devadasis*. *Devadasi* system continued in southern India but in northern India, the destruction of temples by Muslim invaders led to a decline of the institution (Nag, 2001b).

From the early 20th century, the *Devadasi* tradition has been identified as taking advantage of low-caste communities often leading to prostitution. Many reformatory and social revivalist movements started at this age to address the issues around *Devadasi* cult and as a result, of this efforts, the following laws were passed in the State Assemblies since the 1930s (Nag, 2006; Shankar, 1990). The first such law initiated by Bombay Government, which known as the Bombay *Devadasi* Protection Act 1934. Then, Madras *Devadasi* Prevention Act in 1947, Karnataka *Devadasi* Prohibition of dedication act 1981 and Andhra Pradesh *Devadasi* Prohibition Act 1987 came into existing (Nag, 2006). The Karnataka *Devadasi* Samarpana Nishedhana Act (Karnataka *Devadasi* Prohibition of Dedication Act) took effect from January 1984. According to this act, the dedication of women or girls to any deity/temple or object of worship is prohibited and any person who directly or indirectly supports the dedication of women as *Devadasis* is punishable with a penalty of Rs/ 2000 to 5000 and/or imprisonment. Under this act, special provisions are made to rehabilitate *Devadasis* (Kalpana Kannabiran, 1995). However, despite all these legal reforms, prohibiting the dedication of girls as *Devadasis* has been quite ineffective so far (Leela Sampige,

2004; O'Neil et al., 2004; Orchard, 2004; Sampark, 2002; Shankar, 1990).

Today, the social organization of *Devadasi* tradition has changed, and the dividing line between a commercial sex work and *Devadasi* turned to sex work is fragile. Still a very high number of girls from lower caste are entering sex trade in Northern Karnataka districts. As per recent estimation by Karnataka State AIDS Prevention Society (KSAPS), there are about 10000 *Devadasi* or initiated women currently practicing sex work in Bagalkot, Vijayapura and Belagavi districts that are the study Districts for present research (KSAPS, 2014). According to Blanchard et al., *Devadasi* form of sex work is common in Karnataka state with >25% of all FSWs being part of the *Devadasi* system. Further compared to the non-*Devadasis*, *Devadasi* sex workers are significantly more likely to live in rural areas, have never married and to be currently cohabiting with a partner who is not a spouse. Also, more than 80% of *Devadasis* are unable to read or write, entered sex trade at much younger age (mean age 15), entertain clients at home, reported a higher average number of sex partners in the past week and charged less on average to each client. Notably, *Devadasi* FSWs were less likely to migrate to work at another location within the state of Karnataka but were somewhat more likely to have migrated to another state for work (Blanchard et al., 2005). Ethnographic work by O'Neil et al. also recognized the *Devadasis'* migration to Mumbai and other places in Maharashtra and emphasized the importance of understanding their migration to design an effective HIV prevention program (O'Neil et al., 2004).

2.4 Linking the Epidemic: migration, female sex worker and HIV transmission

2.4.1 Migration and HIV transmission: global evidence

There are an increasing evidence and growing recognition of the importance of migration and mobility in the spread of HIV infection. Although HIV/AIDS was first reported only as recently as 1981, the voluminous literature on the disease itself and its relationship with migration has been available globally and within India since the 1990s. In particular, there are many books and collections of papers devoted to the issue. These include a special issue of *International Migration* Vol. 36, No. 4, 1998 and books edited by Herdt and Haour Knipe (Haour-Knipe, 1996; Herdt, 1997). There are also have been several key articles and papers addressing the issue of migration and HIV/AIDS (Caldwell, 1997; Decosas, 1995). A global review summarizing the state of knowledge on migration and HIV/AIDS can be found in the article by Appleyard et al. (Appleyard, 1998). Guest (Guest, 1999) given an overview of the implications of population mobility for HIV/AIDS in Asia. Much additional insight into the situation in Asia contained in the essays by Linge and Porter (Linge, 1997). Skeldon provided pieces of evidence, focusing on Southeast Asia (Skeldon, 2000). These studies report that migration not only facilitates the rapid spread of the virus along the so-called corridors of migration but also cause behaviors and situations that make migrant vulnerable to HIV risk.

As stated earlier, migration is an important factor in the global, regional and local spread of HIV and mobile populations have higher HIV infection rates than those who do not move (Quinn TC, 1994; Webber, 2007). To support this statement, there have been some studies within India and globally demonstrated the relationship between migration and HIV/AIDS. One of such most comprehensive

study of migration and HIV/AIDS was carried out in Kenya, testing the hypothesis that male and female migrant in urban and rural settings are more likely than are non-migrant to engage in sexual practices that elevate their risk of acquiring HIV and consequently AIDS (Brockhoff, 1999). The authors used the 1983 Demographic and Health Survey (DHS) data from Kenya and test this relationship. They conclude that while there was evidence of a possible relationship between migration and high-risk sexual behavior in Kenya, the relationship is not consistent across different gender and migration flow groups (Brockhoff, 1999).

Weerakoon quotes many cases in her article on International female labor migration: implication of the HIV/AIDS epidemic in the Asian region. Her research article says, migrants returning homes are a greater source of risk than the non-migrant population. A study of 494 HIV-positive individuals in South Korea in 1991 included 78 sailors, 70 nationals returning from abroad and only 21 foreigners. In the Philippines, 39 of 335 people diagnosed with HIV between 1984 and 1992 believed they had contracted the disease while working overseas and in 1995, 158 of 668 people known to be HIV positive had been overseas contract workers (Weerakoon, 1997).

In 2001, it was reported that half of the 8,000 Sri Lankans with HIV/AIDS are returned migrant workers. This led Sri Lankan government officials to develop a health module to be given to all intending overseas contract workers from Sri Lankan Bureau of Foreign Employment (SLBFE) Centers across the island (Kickbusch, Hartwig, & List, 2005).

More recently a study from Kenya using Demographic and Health Survey data indicates that, as compared to non-migrants, migrants are more likely to report fear of HIV infection, perceive

themselves as being at risk of HIV infection, less likely to use the condom and significantly correlated with multiple sexual partners. Also, migrants on average are significantly older and more likely to be married than non-migrant (Kimuna, 2012).

2.4.2 Role of migration in spreading HIV/AIDS in India:

Despite declined rate of HIV prevalence among migrants in India from 2.35 in 2008-09 to 0.99 in 2010-11, many evidence has highlighted that migration has been fueling India's HIV epidemic (NACO, 2011-12). Studies on the relationship between migration and HIV conducted by NACO in three popular migration corridors — Ganjam-Surat, Darbhanga-Delhi, and Azamgarh-Mumbai showed that two to four times more number of informal workers had non-regular partners or visited sex workers with only 25% using condoms. Around 5% male migrants and 13%, female migrants reported sexually transmitted infections, nearly double the national average (Saggurti N, 2011). According to NACO, the risk of HIV infection for migrants seems to arise from a multitude of factors - risky behavior, lack of social and economic security and involvement in peer-driven risk taking activities such as drinking alcohol (NACO, 2007).

In a recent study by UNDP, through Population Council, the risk of HIV among migrants was reported to be 1.68 times more likely than non-migrants. The majority of migrants are also often poorly educated, with majority reporting less than five years of formal education. This contributes to limited knowledge of HIV transmission (Saggurti N, 2011). A study conducted with male migrant and FSWs from 14 districts of four high prevalent Indian states shows the prevalence of alcohol consumption before sex and its association with inconsistent condom use during paid as well as unpaid sex among male migrant (Verma, Saggurti, Singh, & Swain, 2010). An ethnographic study conducted in 30 villages in the northern parts of

Karnataka revealed that 40% of single men and 35% of married migrant men had non-marital sexual relationships in the last 12 months (Halli, Blanchard, Satihal, & Moses, 2007).

For a long time, India has lived with the belief that migrants are at risk only at destination sites when they are away from home and their spouse. However, recent evidence proves otherwise. Returned migrants continue to fuel the epidemic since most infected migrants tend to go back to the source when they are sick. A study of married men found returned migrants were 3.86 times as likely to be HIV-positive as compared to active married migrant men. Among men reporting sex with a non-spousal unpaid female sex partner in the past year, only 19% of men reported consistent condom use. This impacts the women and spouses of informal workers/migrants at the source, making them vulnerable to infections from their husband (N. Saggurti, Mahapatra, Sabarwal, Ghosh, & Johri, 2012; Saggurti N, 2011). Another study conducted in two high out-migration districts namely, Prakasam in the southern state of Andhra Pradesh and Azamgarh in the northern state of Uttar Pradesh reported male migrant risky behavior in the home setting. The study results suggest that sexual activity was common in the place of origin among male migrant, and an around 50% of migrant had sex with non-spousal female partners and two-fifth had initiated sex in this setting (Ganju, Mahapatra, & Saggurti, 2013).

2.4.3 Migrant female sex worker and HIV/AIDS

The global literature suggests that women, in general, are becoming more vulnerable to HIV infection, because of the heterosexual mode of transmission, higher biological vulnerability, weaker economic status and powerless situations and often coerced into sexual relationships, than men (Bandyopadhyay, 2000). These factors make all women at risk, but migration can on occasions

exacerbate these elements of vulnerability. While migration often depicted as an empowering process for women, the reality is that migration may result in maintenance of their powerlessness, or they may even be disempowered by moving (Hugo, 2000b). The latter occurs because migrant women may move into occupations where they are at greater risk of the unprotected sexual act. For example, the large movement of women who involved in the sex industry. The fact that they may be undocumented and not protected by laws at the destination, they may lack knowledge about the destination that exposes them to exploitation, they may not be able to access medical facilities at the destination, and they may experience sexual exploitation, rape and sexual molestation (Hugo, 2001).

Research on migrant female sex workers in multiple settings has documented their elevated risk for sexually transmitted infections (STIs) and HIV/AIDS (Choi, 2007; Hagan, 2007). Several prior studies have focused on sex workers in Moscow. Aral et al. (Aral, 2003) highlighted the social organization of sex work, describing that migration patterns created a demand for and supply of sex workers: male migrants away from their families and migrant women who needed income. Other studies have suggested that higher risks could associate with such specific migration-related factors. Those factors includes; mobility, social exclusion, poor access to health care, violations of human and civil rights, younger age, low self-efficacy, lack of resources, lack of knowledge, attitudes of service providers, fear of violation of privacy, and involuntary sexual acts (Ghimire, 2011; Zimmerman, 2003).

A cross-sectional behavioral survey with 5498 mobile female sex workers living in the four high prevalence states of India reported that, female sex workers with a greater degree of mobility reported, physical violence, consumed alcohol before sex, inconsistent condom

use in sex with clients. Additionally, short duration visits and visit to the Jatra (religious fair) places found to have significant association with their inconsistent condom use in sex with clients as well as continuation of sex despite of having sexually transmitted diseases (N. Saggurti, Jain, A. K., Sebastian, M. P., Singh, R., Modugu H. R., Halli, S.S. Verma, R. K., 2011).

Another important study that conducted in northern Karnataka district provides a distinct characteristic of the migrant female sex worker. According to this study, migrant female sex workers are more likely to be brothel-based, have higher income from sex work, speaks more than two languages, have more number of clients and have more sex acts per day, as compared to non-migrant female sex workers in this region (Banandur et al., 2012).

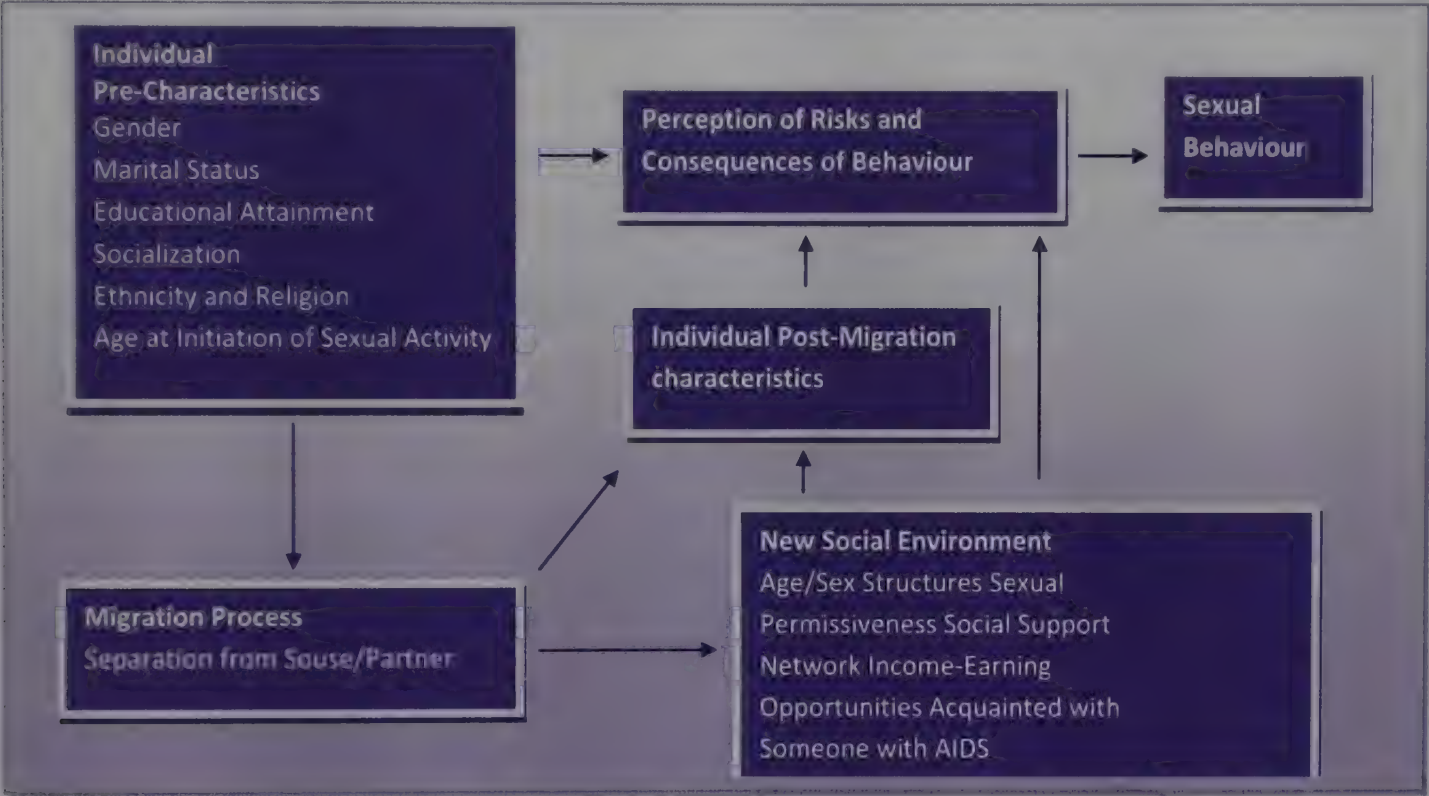
2.4.4 Migrants sexual behaviour in HIV transmission:

Mobile populations can link zones of disease emergence to low prevalence or non-endemic areas through rapid or high-volume international movements, or both (Gushulak BD, 2010). However, HIV/AIDS and migration do not have a linear, cause-effect link but they are known to be linked laterally (Bailey A, 2008). Being a migrant is not a risk factor in itself, but the process of migration and integration into local communities can expose the migrant to the risk of acquiring infectious diseases (Bailey A, 2008).

Skeldon argues that it is not so much the migration that is important as the behavior of the migrants. He further argues that as long as the people moved and did not engage in the kind of activities that are known to spread the disease is unlikely to get a disease. Thus, it is the combination of migration and high-risk behavior with people who already carrier that is central to the topic (Skeldon, 2000).

Brockerhoff and Biddlecom had developed a conceptual model (Figure 2) of the influence of migration on sexual behavior and said, riskier sexual behaviors among migrant groups have attributed to three factors. Those factors include, 1) predisposing individual characteristics: 2) changes in individual attributes due to migration, notably separation from a spouse or partner: and 3) exposure to a new social environment, featuring different sexual norms, opportunities and constraints that result in behavioral modification (Brockerhoff, 1999; Hugo, 2001).

Figure 2: Conceptual model for the influence of migration on sexual behavior



Source: adopted from Brockerhoff and Biddlecom, 1999 in Hugo G 2001.

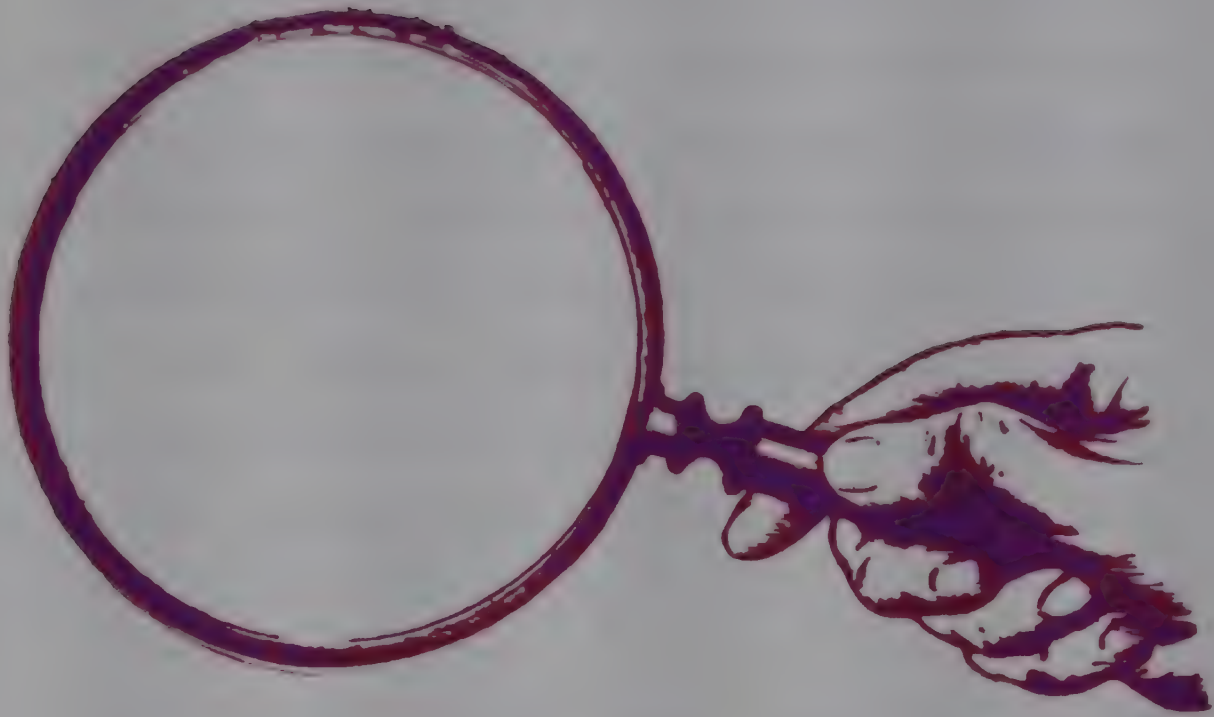
They have closely related this model to the health belief model (HBM), a model often used in studies of health and contraceptive behavior (Janz, 1984). In brief, the HBM assumes that an individual's characteristics, prior experiences and current surroundings shape his or her perceptions concerning the risks and severity of behavioral outcomes such as contracting the HIV through sexual conduct - and thereby influence behavior (Brockerhoff, 1999).

The above literature review on sex work, migration and HIV/AIDS shows the role of migration in HIV transmission. It indicates that migration per se does not cause HIV; rather it causes conditions which heighten HIV risk among migrants. A significant proportion of female sex workers from northern Karnataka districts have been traveling to different places within the district and out of the state for sex work and a huge variation found in their mobility patterns. Also, FSWs who have been moving from this region are engage in high risk sexual behavior and practice sex work in more controlled environment. But unfortunately, it has not been completely understood yet and as of now, very less programmatic emphasis has been given on migrant FSWs in this region.

Therefore, understanding the issues around migrant FSWs and develops an appropriate intervention to provide required support to protect them from the threat of HIV and AIDS is the need of the hours. But to achieve this, it is very much essential to understand the profile of FSWs who are moving from this region, their migration and mobility patterns and the sexual behavior in different places they practice sex work is very much essential. Therefore, this study using both quantitative and qualitative research methods is intended to increase the knowledge about the migration patterns, determinants, and associated HIV risk and vulnerabilities among rural and urban FSWs in three northern Karnataka districts.

The specific objective of this study is to understand the socio-demographic and sex work of profile, compare the migration and mobility patterns, analyze the predictors of out migration and describe the sexual behavior and associated HIV risk and vulnerabilities among rural and urban FSWs in three northern Karnataka districts.

CHAPTER-3



METHODS AND MATERIALS

CHAPTER 3

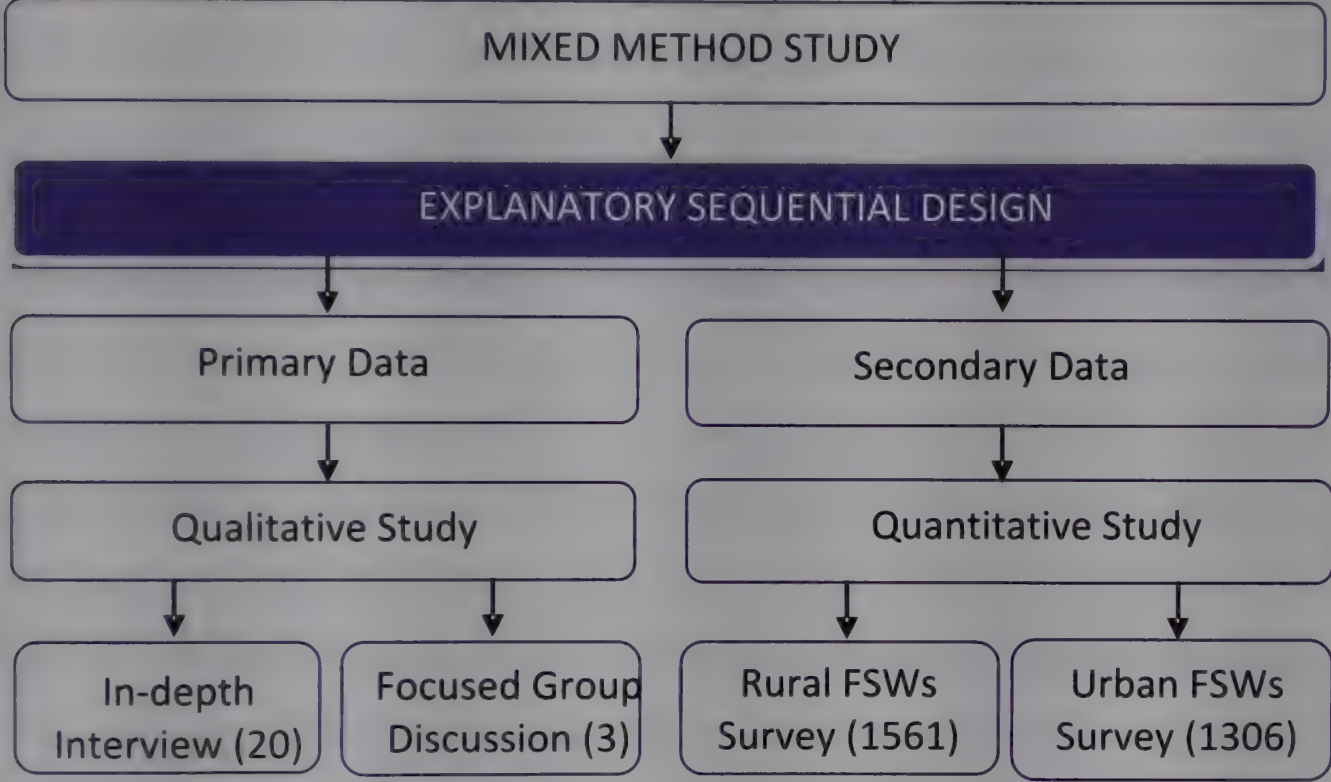
METHODS AND MATERIALS

This chapter about the research methodology provides an overview of the different methods applied for data collection and analysis. Both quantitative and qualitative research methods described in detail, including the rationale for adopting sequential explanatory mixed method approach. A detailed description of study sites, study population, and the definition of the migrant, mobile and local FSWs are depicted in this chapter. Further, the chapter also presents sampling frame for quantitative and qualitative type of data collection, data analysis, data triangulation and the ethical considerations for the study.

A mixed methods research design comprising of cross-sectional survey research (numeric) and descriptive qualitative interviews (text) have been used. Mixed method research is defined as research in which researcher collects and analyzes data, integrates the findings, and draws inferences using both qualitative and quantitative approach in a single study (R. Burke. Johnson, 2007). Within mixed methods, sequential explanatory design was employed for this study and quantitative followed by qualitative data has been collected and analyzed in two distinct phases (John W. Creswell, 2011). Using sequential explanatory mixed method design, in the first phase, analysis of the secondary source of quantitative data that collected in a cross-sectional survey has been done. Then in the sequence, collection and analysis of qualitative data in the second phase have helped to explain or elaborate on the quantitative results obtained in the first phase. In this design, the second phase qualitative findings are built on the first phase quantitative survey, and the two phases are connected in the intermediate state in the study. The rationale for using this

approach was to obtain a general understanding of migration patterns and associated HIV risk through quantitative data analysis and then to refine and explain the statistical results by exploring participant's views in a more detailed way through qualitative data analysis. This method is also proven as a well-suited approach to the investigation of the often hidden and stigmatizing behavioral and social factors underlying HIV epidemics (Poundstone, Strathdee, & Celentano, 2004). It has also helped in providing external validity to the data through triangulation(Fenton, Johnson, McManus, & Erens, 2001).

Figure 3: Explanatory sequential study design



Primary data includes descriptive qualitative In-depth interviews (II) and Focused Group Discussion (FGD) with local, mobile and migrant female sex workers from three study districts. The semi-structured interview guide for in-depth interviews and FGD were drawn up partly based on the key findings from the quantitative interviews, and purposive sampling technique was used to select participants for the study. The main purpose of the qualitative phase was to explain the initial quantitative results in a more in-depth way including changes in migration pattern of women, first experience as a

migrant, facilitators of migration and the local FSWs perception about migration and migrant sex workers. Also, the qualitative study has greatly contributed to understanding the nuances of sex work environment along with answering the specific quantitative results that called for an additional explanation. Combinations of primary and secondary data have made this study technically strong as well.

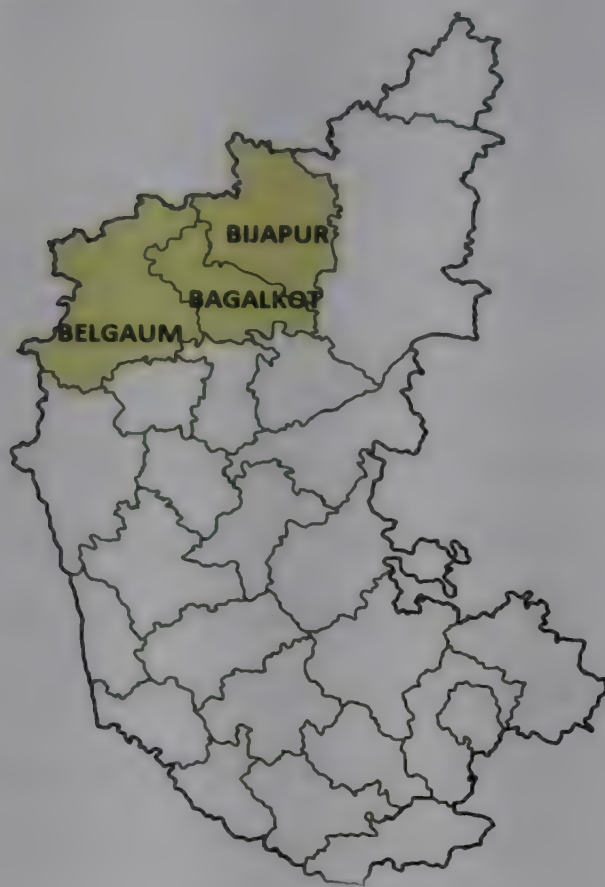
The secondary data utilized in this study includes a cross-sectional survey of 2867 female sex. Conducting a large-scale study with marginalized communities like female sex workers requires an extended period, resources and collaborations with different stakeholders (Family Health International, 2000; Saidel et al., 2008; Shaver, 2005). Also, community involvement is a critical part to gain trust and building rapport with study participants for an ethical conduct of a study (Shaver, 2005; Vadivoo et al., 2008). Considering the limitations of time and resources available for research, I have utilized survey data as a secondary source, which has the representative sample of FSWs from three study districts. Moreover, as part of my association with Karnataka Health Promotion Trust (KHPT-which was primarily responsible for the quantitative survey), I was also involved in designing the survey questionnaire, training the research team, collecting and monitoring the survey data and the same data has been utilized in the present study. Permission from the principal investigator of the study has been taken for utilization of data, and it is certified that this data set has not been published or not used by any other researcher for a Ph.D. or any other dissertation.

3.1 Study sites and population

The study was carried out with female sex workers from Bagalkot, Vijayapura and Belagavi districts in the northern part of Karnataka State. These three districts are mainly agricultural districts with a majority of the inhabitants living in rural areas. Bagalkot,

Vijayapura and Belagavi districts differ in many ways, including socio-demographic characteristics, geographic distribution, and availability of health facilities. These factors are discussed explicitly in the following subsection.

Figure 4: Karnataka state map



Source: from official website of Government of Karnataka

Bagalkot district is located in the northern part of Karnataka and surrounded by Vijayapura district in the north, Gadag district in the south, Raichur district in the east, Koppal district in the southeast and Belagavi district in the west. The district has six talukas namely; Bagalkot, Badami, Hungund, Mudhol, Jamkhandi and Bilgi (Figure 5) (Bagalkot district statistical officer, 2013). As per 2011 census, the total population of Bagalkot district is 18.8 lakhs, and more than one-fifth of the total population belongs to scheduled castes (SC, 16.9%) or Scheduled Tribes (ST, 5.10%). The literacy rate is 68.82% with 79.23% for males, and 58.4% for females.(Bagalkot district statistical officer, 2013).

Figure 5: The Bagalkot district map



Source: district statistics office, Bagalkot

The district has a vast network of public health facility including one district hospital, five taluka hospital, eight community health centers (CHCs), 47 primary health centers (PHCs) and 233 sub-centers (Bagalkot district statistical officer, 2013). Specific to HIV prevention services, the district has 69 Government run HIV testing centers, 4 Government recognized blood banks, 3 STD clinics, 3 ART centers and ten link ART centers as of 2014 (KSAPS, 2014). Sex worker community-based organization (CBO) called, *Chaitanya AIDS TadeGattuva Mahila Sangha* (Chaitanya Mahila Sangha, 2015) implements the Targeted Interventions for FSWs and *Milana* a CBO MSM implements the HIV prevention programs for MSM community in the district.

Vijayapura district lies in the north-east part of Karnataka state and shares border in the east by Gulbarga district, on the southeast by Raichur district, on the south by Bagalkot district on the west by Belagavi district, on the northwest by Sangli district and the north by Solapur district of Maharashtra state. The total population of the district as per 2011 census is around 21.7 lakhs that also includes around 22% of schedule caste (SC) (20%) or schedule tribes (ST) (2%) (Office of the Registrar General and Census Commissioner,

2011). The district has five talukas namely: Vijayapura, Basavana Bagewadi, Indi, Muddebihal and Sindgi (Figure 6). The literacy rate is 67%, and it is substantially higher among males (77%) than females (57%) (Vijayapura district statistical officer, 2013).

Figure 6: The Vijayapura district map



Source: district statistics office, Vijayapura

Public health facility wise, the district has one district hospital, four taluka hospitals, nine CHCs, 64 PHCs and 314 sub-centers (Officer, 2013). As of 2014, there are 66 government-run HIV testing centers, six government recognized blood banks, 3 STD clinics, 2 ART centers and five-link ART centers in the district to provide HIV-related services (KSAPS, 2014). *AIDS Jagruthi Mahila Sangha* and *Navaspoorthi* are implementing the HIV prevention interventions with FSWs and MSM communities respectively

Belagavi is situated in the north-western part of Karnataka state and bounded on the west and north by Maharashtra state, on the northeast by Vijayapura district, on the east by Bagalkot District, on the southeast by Gadag district, on the south by Dharwad and Uttara Kannada district, and on the southwest by the state of Goa.

The district has been administratively divided into ten talukas namely; Athni, Bailhongal (Sampgaon), Belagavi, Chikodi, Gokak, Hukeri, Khanapur, Ramdurg, Raybag, and Saudatti (Parasgad) (Figure 7) (Belagavi district statistical officer, 2013). As per 2011 census, districts’ total population is 47.7 lakhs with 19% of the population belonging to SC (12.8%) or ST (6.2%). The literacy rate is 74%, being substantially higher among males (83%) than among females (65%) (Office of the Registrar General and Census Commissioner, 2011).

Figure 7: The Belagavi district map



Source: district statistics office, Belagavi

The district has a vast network of public health services including one district hospital, nine taluka hospitals, 16 CHCs, 147 PHCs, 598 sub-centers (Belagavi district statistical officer, 2013). As of 2014, the district has 129 government-run HIV testing centers; six government recognized blood banks and 4 STD clinics. There are 3 ART centers and 11 link ART centers at different health facility levels. “*Shakthi AIDS Prevention Women’s Sangha* and *Sweekar* are two CBOs

working in the district with FSWs and MSM community respectively along with a Non-governmental Organization (NGO) called, Belagavi Integrated Rural Development Service Society (BIRDS), which has a longstanding history of an association with marginalized communities in the district.

There are quite a few inherent similarities among these districts, which arguably contribute to high HIV prevalence in the region. The similar factors contributing to the increased incidence of HIV in these districts include: (a) the presence of higher number of female sex workers (per capita) compared to the rest of the state, (b) the existence of a traditional system of sex work known as the *Devadasi* tradition, (c) a higher proportion of men who report visiting commercial sex workers, relative to the rest of the state and (d) high prevalence of interstate migration, specifically from Karnataka to Maharashtra, among sex workers (Blanchard, Halli, et al., 2007).

Most recent estimation by Karnataka State AIDS Prevention Society (KSAPS) in the 30 districts of Karnataka state confirms that more than 20% of total number of FSWs in Karnataka state resides either in Bagalkot, Vijayapura or Belagavi districts (KSAPS, 2014). As of 2014, the total number of FSWs in 30 districts of Karnataka state was 87108 and out of them, around 5255 are from Bagalkot, 2947 are from Vijayapura and 9622 are from Belagavi district (KSAPS, 2014). More interestingly, an average of 70% of the total of 17824 FSWs from these districts entered the profession through a *Devadasi* tradition and this is proportionally high among FSWs from Bagalkot and Vijayapura as compared to Belagavi and the reason for this is not well known. A study conducted in Bagalkot district indicates that an average 12.3% of rural men in the district reported ever visiting a female sex worker, with a higher proportion of married men reported this behavior than unmarried men.

Bagalkot, Vijayapura, and Belagavi district have a longstanding history of FSWs migration from the rural area to nearby Maharashtra districts such as Sangli, Satara, and Solapur as well as to the large urban centers of Mumbai, Pune, and Goa (Banandur et al., 2012). Often, the movement is from rural regions to urban centers where HIV prevalence is much higher, and high-risk behaviors are more frequent (Blanchard, Halli, et al., 2007; Blanchard et al., 2005).

In this context, the study was conducted in rural and urban centers of Bagalkot, Vijayapura and Belagavi district to understand the migration and mobility pattern of female sex worker and this is crucial for designing effective and comprehensive HIV prevention programs and services.

3.2 Definitions

Migration and mobility are two distinct concepts. Mobility is when a person moves from the place of origin, travels/works and returns to origin the same day or week (for example people who live in Bagalkot and work in Belagavi). On the other hand, migration involves a movement of those people who establish residence at the destination for a significant period (NACO, 2007). This study used following operational definitions to classify the migrant, mobile and local female sex workers who took part in both quantitative and qualitative study. This distinction has been made based on their movement as it relates to sex work within past one year.

(a) Migrant FSWs:

- An active female sex worker (18 years of age or above).
- Has moved (in the past one year) either outside her district and/or outside her state for sex work.
- Has stayed out for a minimum of two weeks.

All three criteria need to be satisfied to qualify as a migrant FSW.

(b) Mobile FSWs:

- An active female sex worker (18 years of age or above).
- Has moved (in the past one year) either within her district and/or outside her district/state for sex work.
- Has stayed for less than two weeks outside her district/state.

(c) Local FSWs:

- An active female sex worker (18 years of age or above).
- Has never moved either within her district and/or outside her district/state for sex work.

3.3 Study design

3.3.1 Qualitative study design:

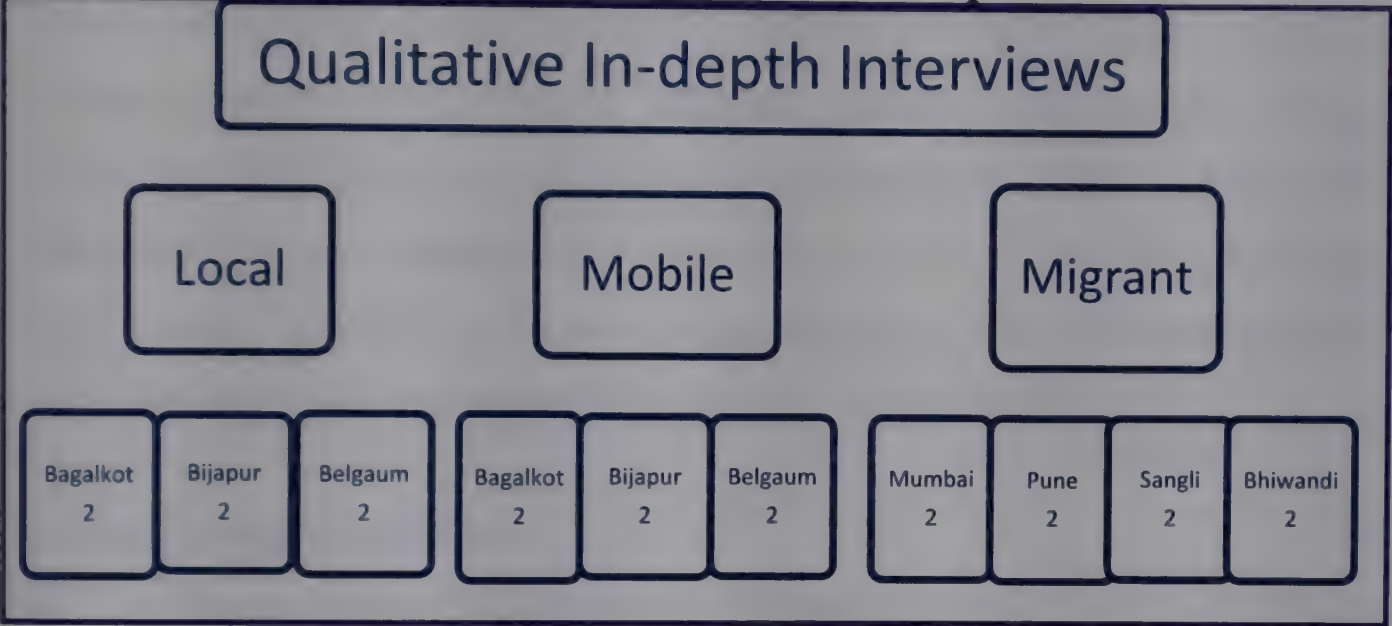
Qualitative data was collected using qualitative techniques such as In-depth Key Informant Interviews and Focus Group Discussion. As stated above, the aim of the qualitative data collection was an in-depth investigation and interpretation of the initial key quantitative results and also to further examine the changes in sex work environment and practices over time. The qualitative study was guided by the principles of diversification and saturation to get all required information. Different locations were taken as a component of the diversification within each group. The saturation provided guidance as to the number of interviews to be conducted i.e. when those interviews won't provide a new element for the conceptual themes as well as for the general context.

In-depth interviews:

In-depth interviews with key informants included both rural and urban female sex workers from 3 study districts. Participants were selected based on purposive sampling to increase the scope or range of data exposed as well as to uncover the full array of multiple

perspectives (Chandra Poojary, 2009; Lincoln & Guba, 1985). In order to do this, the study sought to include two local and mobile FSWs from each of the three districts. For migrants, FSWs who visit four major destinations in Maharashtra were considered and selected two from each of those four major destinations. The resulting in-depth interview sampling strategy is depicted in Figure 8. Participants did not take part in both FGDs and in-depth interviews to achieve maximum diversity within the study population.

Figure 8: Sampling frame for qualitative in-depth interviews



In total, 20 in-depth interviews were conducted, and the informants were identified with the help of local CBOs. Semi-structured interview guide specific to mobility status was designed for all three groups of participants, and the interview tools are field tested before conducting an actual interview. After the field testing, the question route was altered again, and more local words were incorporated. The principle investigator conducted all 20 in-depth interviews in the local language Kannada, and each interview ranged from 30 to 60 minutes. All informants were interviewed individually to provide privacy, particularly given the sensitive nature of the topics discussed. The interviews were conducted at locations where participants were comfortable, and the places include respondent's

home, local CBO clinic/office, and brothels. Consent was obtained from respondents before interviews were initiated and permission was obtained for audio recording the interviews. In this thesis, pseudonyms are used for respondents to protect their privacy.

Interviews began with a general introduction of the researcher and the research. Participants were given the option to stop or quit the interview at any point and of not answering the question. Broader topic for the in-depth interviews along with relevant probing includes: (1) sex work initiation and life stages, (2) sex work environment at source and different destinations, (3) different sex partners including clients, regular partners and intimate partners, (4) attitudes about condoms and, (5) access to health resources in the past and present. Data quality was monitored by periodic review of the collected data and also the taped interviews were played by the researcher to monitor and where it was relevant to improve the subsequent interviews.

Focus group discussion:

Focus Group Discussions (FGD) are instrumental in soliciting a wide range on opinions and exploring new issues that may arise (Bailey A, 2008; Chandra Poojary, 2005). In total, three FGDs with each local, mobile and migrant group of FSWs were organized to acquire information about a range of issues around the migration of FSWs. To encourage the discussion of differences based on location, migrant FSWs from three study district representing four major destinations were considered for the FGD. Altogether 18 participants (five local, six mobile and seven migrant FSWs) were part of the three different FGDs. All three FGDs were conducted centrally in a CBO office at Mudhol (Bagalkot district) which is closer to the participants from all three study districts. The FGDs lasted from 30 minutes to one hour, and consent has taken from all individuals for their willingness to participate in group discussion and audio recording of the

discussion. Principle investigator of the study facilitated all three FGD in Kannada language and a colleague working with KHPT has helped in taking notes. All three FGDs were audio recorded. The note taker has taken notes of key issues discussed in the group and drawn a seating chart (Appendix 9) that helped in analyzing the transcripts from FGDs.

A semi-structured FGD guide was developed based on the key findings of the quantitative survey and after field testing, the guide was refined to include the pertinent question for each study subpopulation. FGD guide includes questions about recent trends in FSWs migration and health facility available at specific destinations. Non-migrant FSWs were specially asked about their perceptions of migration and migrant sex workers.

3.3.2 Quantitative data source, study design and sample frame:

Karnataka Health Promotion Trust (KHPT) was set up as a partnership between Karnataka State AIDS Prevention Society (KSAPS) and the University of Manitoba, Canada in the year 2003(KHPT, 2015). KHPT focuses on implementing large-scale program initiatives and research related to HIV/AIDS, tuberculosis, and reproductive health. The *Payana* (meaning "journey") project was one such knowledge building initiative of KHPT and University of Manitoba, and the overall objective of the study was to understand the migration patterns and associated HIV/AIDS vulnerabilities among female sex workers in northern Karnataka and southern Maharashtra. The study was funded by 'Avahan' the India AIDS Initiative of Bill and Melinda Gates Foundation. The cross-sectional survey with rural and urban FSWs was carried out from 2008 to 2010. The study was also partnered with local sex worker community-based organizations namely; Chaitanya AIDS Prevention Women's Sangha, Mudhol,

Bagalkot, Jagruthi AIDS Tadegattuva Mahila Sangha, Vijayapura and Shakti AIDS Prevention Women's Groups, Gokak, Belagavi

The data from initial mapping study of sex workers was used as the sampling frame to identify villages and urban town from the three northern Karnataka districts. The initial round of sex workers mapping was done by India-Canada Collaborative HIV/AIDS Project (ICHAP) with a funding support from United States Agency for International Development (USAID). All villages and urban towns in Bagalkot (619 villages and 12 towns), Vijayapura (680 villages and six urban towns) and Belagavi (1255 villages and 22 towns) were included in the rapid assessment of HIV risk (refer Appendix 6 for specifics on the rapid mapping methodology). The data collected from the mapping was analyzed to determine high volume talukas concerning out-migration of FSWs. From the selected talukas, villages and urban towns were first selected randomly using a weighting proportionate to the estimated size of the FSWs population. The selected villages and urban towns were then revalidated by a team of field investigators and community researchers, and the final sampling included villages and urban towns with at least ten residential FSWs and a large number of migrant FSWs. Thus, the final list of villages and the urban town was a result of purposeful sampling ensuring that the study concentrates in those villages and town that show evidence of out-migration. As a result, 142 villages and 24 urban towns were finally selected from 19 talukas of Bagalkot, Vijayapura and Belagavi districts (Table 2).

The target sample size for the rural and urban FSWs was 3000 (consisting of 1500 to 2,000 non-migrants and 1000 to 1500 migrants), depending on availability and response rates. All migrant FSWs from selected villages and towns were included in the study.

Table 2: Distribution of sample villages and urban towns

District	Taluka	# of villages	No of urban towns
Bagalkot	Bilagi	14	-
	Jamkhandi	18	2
	Mudhol	27	1
	Hungundh	-	1
	Badami	-	1
Belagavi	Athani	6	1
	Chikodi	10	2
	Belagavi	-	1
	Gokak	1	2
	Hukkeri	4	2
	Soudatti	6	1
	Ramdurg	15	1
	Raybag	2	2
	Bailhongal	3	1
Vijayapura	Vijayapura	12	1
	Indi	5	1
	Muddebihal	11	2
	Sindgi	8	1
	Basavanabagewadi	-	1
Total # of villages & towns		142	24

For the non-migrant, the study set a target for each taluka, in order to meet the total sample size of 1500 to 2000 FSWs, proportionate to the size of non-migrant in each taluka estimated during the validation process. Finally, the study recruited a total of 2867 (Rural 1561 and Urban 1306) participants from rural villages and urban towns respectively, consisting of both migrant and non-migrant FSWs.

Both migrant and non-migrant FSWs were identified by a team of trained community researchers and field investigators. Community researchers are either former or current sex workers who have work experience in an ongoing community-based sex work intervention in these three districts. The district sex worker community-based organizations have assisted in the identification and selection of these community researchers specifically for this project. The selected

community researchers are trained in identification of sex workers, rapport building, condom promotion, HIV counseling skills and HIV/STI prevention programs in their district. Whenever required these community researchers also served as a link for service delivery for HIV/STI prevention and care services which are delivered by the local HIV prevention program in these districts. The field investigators were preferably from northern Karnataka and comfortable with the local dialect and understand the nature of sex work and the local customs and traditions associated with sex work.

Selection of informants for the study was based on the following criteria: participants must be over 18 years of age, an active sex worker, a resident of Bagalkot, Belagavi or Vijayapura district and sample village/town and willing to participate and provide information with consent. The interviews were conducted in culturally appropriate locations such as home/brothel/community center/ or any other place ensuring privacy and confidentiality and comfortable setting to the FSW. All study participants underwent informed consent before the interviews and were assured that the information provided by them was confidential. The quantitative data collection was done by administering a structured survey questionnaire that was in local language Kannada. The survey questionnaire collected information regarding the women's socio-demographic characteristics, mobility/migration pattern, sexual behavior and exposure to intervention both in the village of origin and the places of destination, HIV knowledge, and risk perception.

All quantitative data was entered in SPSS by a skilled data entry operator. All records coded with unique study ID, and none of the personally identifying information of study participants was

entered in an electronic data file to ensure the confidentiality and anonymity of study participants.

3.4 Data analysis

3.4.1 Qualitative data analysis:

All in-depth interviews and FGDs were recorded on digital audiotapes and were transcribed verbatim, and then translated into English. All transcribed interviews and the translated documents were reviewed by the principal investigator for accuracy and completeness. Transcripts were then imported into NVivo10 (QSR, 2011), a software program designed to assist qualitative data management and analysis. The principle investigator developed a coding scheme based on the interview guide and available literature and added codes/categories that emerged during analysis. After coding was complete, thematic content analysis (Chandra Poojary, 2009; Guest G., 2012) was undertaken by the author with the goal of generating themes and theory that characterize the women's experiences at the time of initiating sex work and offer possible explanations for their heightened risk of contracting HIV. Comparative analysis (Charmaz, 2006) was also undertaken to assess whether certain concepts, relationships among concepts, or positive/negative perspectives were more apparent or experienced differently in one group than in another.

3.4.2 Quantitative data analysis:

Statistical analyzes were conducted using SPSS software version 17.0 and the descriptive statistics were undertaken for socio-demographic characteristics of rural and urban FSWs. To meet objective 1, information collected in Section 5 of the questionnaire was utilized by using bivariate analyzes. Only FSWs, who qualify as migrant/mobile sex worker, have been considered for this analysis (n=1417). Analysis explored the top 5 destinations for rural and urban sex workers in all three districts separately. Also, the data was

analyzed for a difference in the proportion of within and out of state migration among rural and urban sex workers in each district. Inferential analysis assessing characteristics and predictors of migration, duration of stay at the destination, decision making, timing, frequency of visits, reasons for choice and timing was compared between rural and urban sex workers. Unpaired t-tests for means was used to compare differences between rural and urban migrant/mobile sex workers for continuous variables and Pearson's chi-square or Fischer's exact test (where expected cell counts <5) was used for categorical variables. A multivariate analysis was performed using logistic regression. Characteristics that have been previously associated with migration in other studies, or those that are significantly associated with migration at $p < 0.10$ in univariate analyzes have been considered for inclusion in the final model. Characteristics that remain significantly associated with migration at $p < 0.05$ have been retained. For the objective 2, the outcome variables of interest are, being migrant or non-migrant sex workers. The predictor variables were grouped into five categories based on level (e.g., individual, contextual, structural and cultural) (Table 3).

Table 3: Predictor variable for migration and their grouping according to level

Individual factors	Contextual factors	Structural factors	Cultural factors	Outcome variable
Age	Duration Separated /Divorced /Widow	Household size	Religion	Migrant sex worker
Number of children	Age at initiation of sex work	Local (urban/rural)	Caste	Non-migrant sex worker
Age at marriage	Languages spoken	Other contributors to household income	Languages spoken	
Literacy	<i>Devadasi/</i> Non- <i>Devadasi</i>		<i>Devadasi/</i> Non- <i>Devadasi</i>	
Marital status	Other source of income		Marital status	
Locale (urban/rural)	Contribution of sex works toward income			
Household size	Literacy			
Education				

In univariate analyzes, unpaired t-tests for means was used to compare differences between migrant and non-migrant FSWs for continuous variables, whereas Pearson's chi-square or Fischer's exact test (where expected cell counts <5) was used to assess categorical characteristics. Subgroup analyzes for *Devadasi* and non-*Devadasi* sex workers were performed to explore effect modification by type of sex work. Multivariate analyzes were performed using logistic

regression; using the same guidelines for covariate inclusion described above.

3.5 Data triangulation:

The results of the quantitative survey were analyzed in the light of findings from the qualitative data. This triangulation helped to confirm, cross-validate, and corroborate findings from the quantitative survey method in a more holistic way. The findings from the quantitative and qualitative data have been brought together in the chapter on results. The study findings are discussed in detail in the backdrop of the study objectives, existing evidence and the study framework to delineate the research, and for programmatic and policy implications.

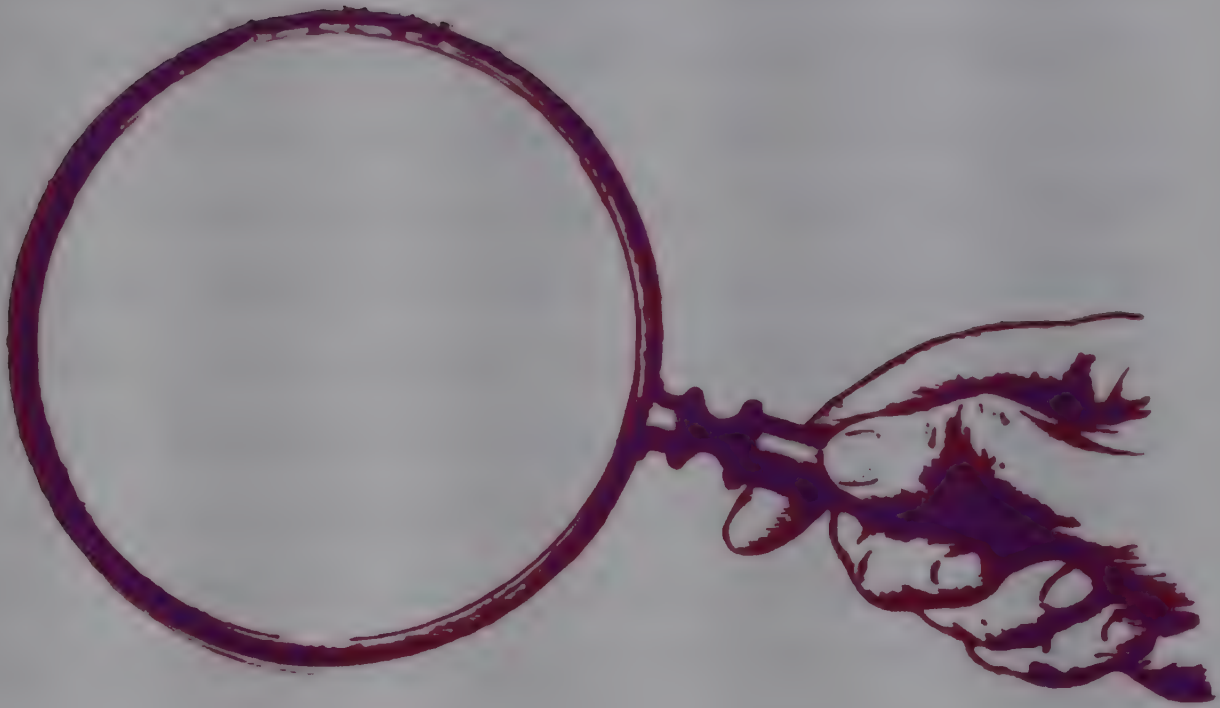
3.6 Ethical considerations:

This study involved members of highly stigmatized and marginalized groups, and a high degree of ethical standards were followed right through the study to ensure that all participants were protected from potentially harmful circumstances. Ethical approval for the larger quantitative survey has taken from the St. Johns Ethical Review Committee, Bangalore and the qualitative study design and tools were discussed, and formal approval has been obtained from my Ph.D. research committee in CMDR.

During quantitative and qualitative data collection, the purpose of the study was informed to the respondents, and it was ensured that all participants understood the purpose of the study well. Also, all participants were informed of their right to withdraw from the study at any time. A written informed consent was administered to all respondents, and their signature was taken. All interviews were conducted in culturally appropriate locations such as

home/brothel/community center, local CBO office/clinic to ensure the privacy and confidentiality of respondents. All records were coded with a unique study ID, and none of the personally identifying information of study participants was entered in the electronic data file to ensure the confidentiality and anonymity of respondents.

CHAPTER 4



SOCIO-DEMOGRAPHIC AND SEX WORK PROFILE

CHAPTER 4

SOCIO-DEMOGRAPHIC AND SEX WORK PROFILE

This chapter presents results for the first research objective and aim to understand the socio-demographic, and sex work profile of rural and urban FSWs in northern Karnataka district. Both quantitative and qualitative findings were presented in this chapter. For socio-demographic information, respondents age, literacy level, religion, language speaks, marital status, age at marriage, number of children and household size were presented in detail. Similarly for sex work characteristics, respondents age at start of sex work, reasons for enter into sex work, duration in practicing sex work, and their income and other work apart from sex work were depicted comprehensively. This information on FSWs profiles in northern Karnataka will greatly helps to plan and work with their issues around migration for sex work and associated HIV risk and vulnerabilities in future.

4.1 Socio-demographic profile:

Total 2867 FSWs participated in the quantitative survey and among them, 1189 are from Belagavi, 1226 are from Bagalkot and 452 are representing Vijayapura districts. Of the total participants in the study from three districts, 1561 are rural, and 1306 are urban FSWs. With respect to migration and mobility status, more than half (50.6%) are local, more than a quarter (35.6%) are mobile and less than a quarter (23.8%) are migrant FSWs. Significant proportion of rural FSWs are migrant (41.2%) and travel long distance for more than two week periods. Whereas compared to rural, a significant proportions of urban FSWs are mobile (41.7%) and travel within the district or state for less than two week periods. The following table 4 depicts the study districts and mobility status of rural and urban FSWs.

Table 4: Percent distribution of FSWs by native district and mobility status according to place of residence

	Rural N=1561 (%)	Urban N=1306 (%)	Total N=2867 (%)	P[§]
Study districts				
Belagavi	437(28.0)	752(57.6)	1189(41.5)	
Bagalkot	873(55.9)	353(27.0)	1226(42.8)	
Vijayapura	251(16.1)	201(15.4)	452(15.8)	
Mobility status				<0.001
Local	728(46.6)	722(55.3)	1450(50.6)	
Mobile	190(12.2)	544(41.7)	734(25.6)	
Migrant	643(41.2)	40(3.1)	683(23.8)	

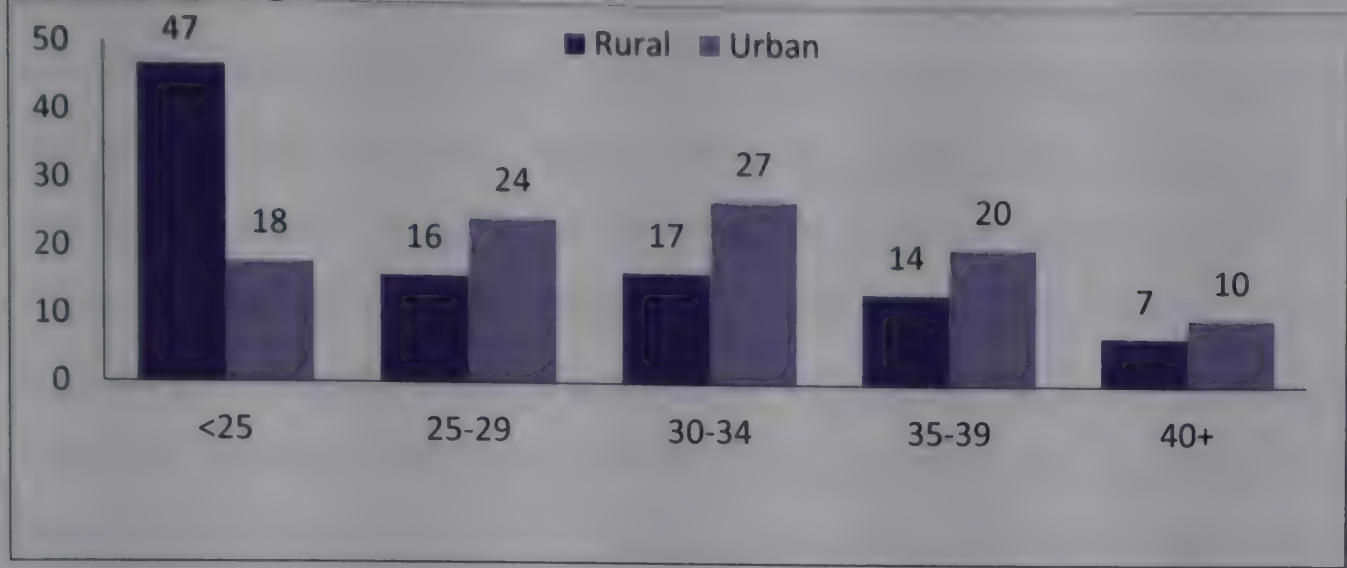
Source: from the field survey of this study.

[§]P-value is for χ^2 test of independence comparing the place of residence.

Current age

At the time of data collection, around half (47%) of the rural FSWs were less than 25 years of age and around 30% are between 25 to 34, 13% are between 35 to 39 and 7% are more than 40 years of age. This is slightly different among urban FSWs. Urban FSWs are distributed in various age categories that include: around 18% are less than 25, 24% are 25 to 29, 27% are 30 to 34, 20% are 35 to 39 and 10% are 40 and above age category. More importantly, a significant proportion of rural FSWs are young compared to urban FSWs. Urban FSWs belong to different age groups. The mean age was 27 (range 18 to 55) for rural FSWs, whereas it is 31 (range 18 to 52) for urban FSWs.

Figure 9: Percent distribution of FSWs by their current age according to place of residence



Literacy:

Regarding literacy (see Table 5), among the total number of FSWs 75% are not able to read and write, and 72% have not attended school. The illiteracy rates among rural FSWs are significantly high (81%) compared to urban FSWs (68%). Also, only 11% of rural FSWs have completed primary education compared to 18% of urban FSWs. This is similar to higher primary (rural 8% & urban 11%) and higher school and above (rural 2% & urban 7%) education in rural and urban FSWs.

Table 5: Percent distribution of FSWs by literacy level and schooling completed according to place of residence.

	Rural N=1561 (%)	Urban N=1306 (%)	Total N=2867 (%)	P [§]
Able to read & write?				<0.001
No	1260(80.7)	895(68.5)	2155(75.2)	
Yes	301(19.3)	411(31.5)	712(24.8)	
Highest level of schooling completed				<0.001
Primary	180(11.5)	231(17.7)	411(14.3)	
Higher primary	131(8.4)	145(11.1)	276(9.6)	
High school & above	32(2.0)	86(6.6)	118(4.1)	
Have not attended school	1216(77.9)	843(64.5)	2059(71.8)	

Source: from the field survey of this study.
§P-value is for χ^2 test of independence comparing the place of residence.

Findings from the qualitative study indicate that many rural and urban FSWs have never attended school or dropped out from the school due to early transition into adult roles via marriage or entry into sex work. This is in part related to the *Devadasi* cultural tradition of sex work, where young girls are dedicated to sex work as part of a religious tradition. The educational needs of these women were seldom prioritized among the mothers who grow up in the *Devadasi* tradition. In sum, low literacy level among women in sex work is the biggest challenge for the HIV/AIDS prevention efforts to make them understand the different prevention messages provided through intervention programs in both source and migration destinations.

Religion, caste and languages known:

Significant proportion (96%) of FSWs from three study districts belongs to Hindu religion (rural 98% & urban 93%) and a very small proportion (4%) of them representing Islam. Muslim respondents mainly reside in urban places (7%), and very few of them are rural residents (2%). A higher proportion of FSWs (76%) from these three study districts belongs to scheduled caste and most of them reside in rural areas (90%). Also a small proportion of FSWs from the same district belongs to other backward class (OBC) (18%), general caste (5%) and resides in urban places. Kannada is the mother tongue of most (92%) of the respondents, and this is 95% among rural and 89% among urban respondents. Almost every respondent who has participated in the study spoke Kannada (100%), the local language. Around 53% of rural and 34% of urban FSWs spoke Hindi, 36% of rural 25% of urban FSWs spoke Marathi and 2% of rural and 3% of urban FSWs spoke Telugu.

Table 6: Percent distribution of FSWs by religion, caste and language proficiency according to place of residence

	Rural N=1561 (%)	Urban N=1306 (%)	Total N=2867 (%)	P [§]
Religion				<0.001
Hinduism	1528(97.9)	1216(93.1)	2744(95.7)	
Islam	30(1.9)	89(6.8)	119(4.2)	
Caste				<0.001
SC	1402 (90.0)	789 (60.0)	2191 (76.0)	
ST	0 (0.0)	24 (2.0)	24 (1.0)	
OBC	136 (9.0)	389 (30.0)	525 (18.0)	
General	23 (1.0)	104 (8.0)	127 (5.0)	
Mother tongue				<0.001
Kannada	1484(95.1)	1165(89.2)	2649(92.4)	
Hindi	19(1.2)	18(1.4)	37(1.3)	
Marathi	47(3.0)	36(2.8)	83(2.9)	
Other	11(0.7)	87(6.7)	98(3.4)	
Number of languages spoken				<0.001
1	551 (35.3)	727 (55.7)	1278 (44.6)	
2	625 (40.0)	354 (27.1)	979 (34.1)	
>2	385 (24.7)	225 (17.2)	610 (21.3)	
Language speaks*				<0.001
Kannada	1554(99.6)	1305(99.9)	2859(99.8)	
Hindi	836(53.6)	453(34.7)	1289(45)	
Marathi	555(35.6)	326(25.0)	881(30.7)	
Telugu	27(1.7)	35(2.7)	62(2.2)	
Other	4(0.3)	2(0.2)	6(0.2)	

* Multiple choice questions

Source: from the field survey of this study.

[§]P-value is for χ^2 test of independence comparing the place of residence.

It is interesting that around 25% of rural FSWs and 17% of urban FSWs spoke more than two languages. Almost everyone speaks Kannada and also Hindi (rural 53% & urban 35%) and [or] Marathi (rural 36% & urban 25%). In qualitative interviews, most of the rural migrant FSWs felt the importance of knowing different languages to practice sex work in different places. Despite Kannada speaking women staying together along with a Kannada speaking brothel owner, most of them felt it is very much essential to know Hindi and Marathi to deal with their clients, police, and mediators who play a

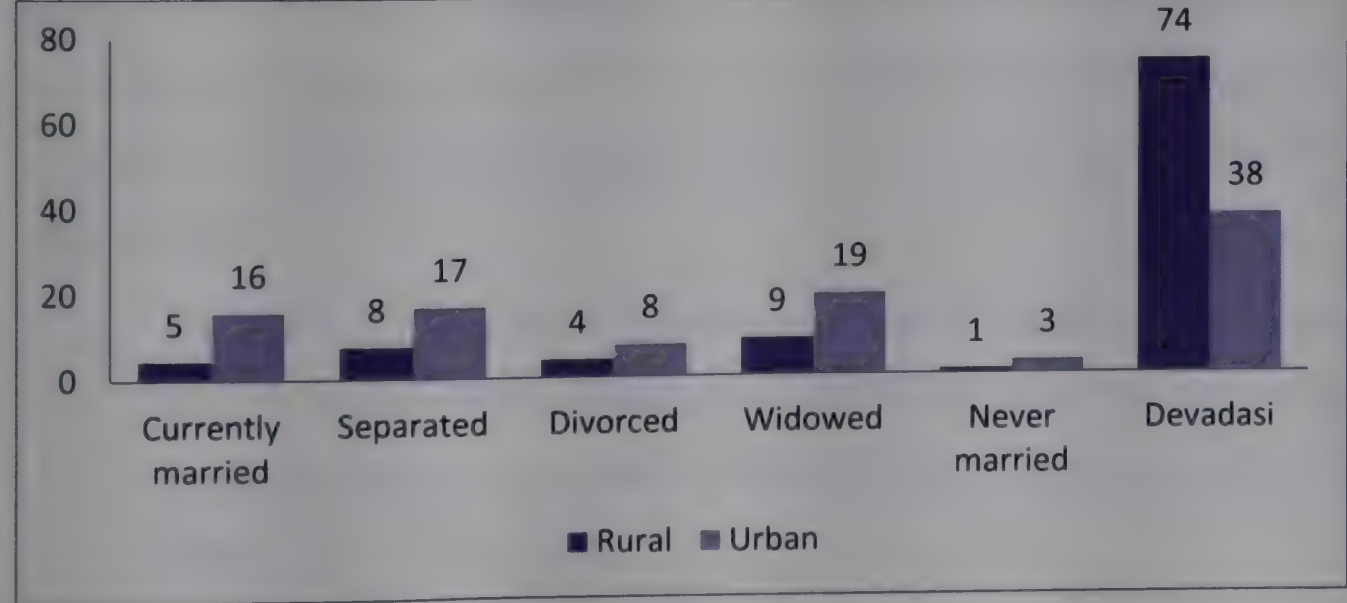
role in the sex work at different destinations. Many of them also said; initially, they had difficulties to convince their clients for condom use since they were not well versed in either Hindi or Marathi. But later they learned Hindi and Marathi by conversing with other women at different destinations.

The language was the biggest problem when I initially moved to Bombay. I had difficulties with clients, and I was not able to manage Police when they arrested me once. But I learned Hindi and Marathi by living there itself and by conversing with others. It took almost a year to learn the language, and now I am very confident (Rural FSW, age 29, Vijayapura)

Marital status:

The marital status (see Figure 10) of the rural and urban FSWs differed considerably. About three fourth (74%) of rural FSWs are *Devadasis*, and this is considerably less (37%) among urban FSWs. Also considerable proportions of urban FSWs are widowed (19%), followed by separated (17%), currently married (16%) and never married (3%). The proportion of widows (9%), separated (8%), currently married (4%) and never married (1%) are less among rural FSWs.

Figure 10: Percent distribution of FSWs by current marital status according to place of residence



Among the total respondents, 390 (25%) rural and 704 (54%) urban FSWs were married at least once in the past. Among the total respondents married once in the past, more than 88% got married before the age 18 (mean 12.94). Marriage before the age of 18 is more among rural FSWs (94% and mean 11.78) compared to urban FSWs (84% and mean 13.52).

Table 7: Percent distribution of FSWs by age at marriage according to place of residence

	Rural N=390 (%)	Urban N=704 (%)	Total N=1160 (%)	P [§]
Age at marriage				<0.001
>10 Year	132 (33.8)	184 (23.9)	316 (27.2)	
11 to 15 Year	184 (47.2)	296 (38.4)	480 (41.4)	
16 to 18 year	51 (13.1)	170 (22.1)	221 (19.1)	
19 to 25 year	13 (3.3)	104 (13.5)	117 (10.1)	
Don't Know	10 (2.6)	16 (2.1)	26 (2.2)	
Mean	11.78	13.52	12.94	

Source: from the field survey of this study.

[§]P-value is for χ^2 test of independence comparing the place of residence.

The qualitative analysis shows the most recent changes in entry into sex work of women from rural places. According to this, in recent days, the practice *Devadasi* tradition is slowly decreasing, and this is due to the fear of government policies or informal restriction at village level by panchayath, including different voluntary groups. But still the proportion of women entering sex work is high. Socioeconomic factors play an important role for many women to choose this profession. Generally, women from the marginalized community, who are separated, or divorced, or widowed and never married are entering into the sex trade in most recent days. One woman from Bagalkot district said:

My sister's "kaagada" [an informal way of divorce] took place and so that she started practicing sex work. Later, no marriage proposal came to me and so that I followed my sister. (Rural FSW, age 22, Bagalkot).

Many *Devadasi* women also felt the women entering sex work in recent days are not respected by the community because they are not *Devadasis*. One *Devadasi* women said, "*Devadasi women are treated like a son, society recognizes them and they even get an equal share in the family property. But the non-Devadasi women are considered as 'suleru' [female prostitutes] and people won't respect them (Rural FSW, age 37, Vijayapura)*".

No of children & household size:

More than 77% of total FSWs have reported of having, at least, one or more biological children. Also, about 85% of them financially support at least one or more children who are not their own or biological. More than half (rural 53% & urban 55%) FSWs reported having one to two biological children and around a quarter of them (rural 19% and urban 27%) have more than three biological children. But an around 27% of rural and 18% of urban FSWs have reported that they do not have any biological children. Specifically, many of the migrant FSWs (36% of rural migrant & 22% urban migrant) have reported of not having children and in the qualitative interviews, many of them also said the brothel madams do not allow them to get pregnant when they are in destination. This is so because the brothel madam has invested on her and the women getting pregnant will be a great loss for the brothel madams.

With regards to household size, significantly high proportion of rural (64%) and urban (68%) FSWs live with the extended family that includes at least 4 to 8 family members and a small proportion of them (Rural 2% & Urban 1%) are living alone.

Table 8: Percent distribution of FSWs by number of children and household size according to place of residence

	Rural N=1561 (%)	Urban N=1306 (%)	Total N=2867 (%)	P [§]
No of living children (own/biological)				<0.001
0	425 (27.2)	235 (18.0)	660(23.0)	
1-2	841 (53.9)	717 (54.9)	1558 (54.4)	
3+	295 (18.9)	354 (27.1)	649(22.6)	
No of children financially supported				<0.001
0	322(20.6)	120(9.2)	442(15.4)	
1	398(25.5)	293(22.4)	691(24.1)	
2	437(28.0)	437(33.5)	874(30.5)	
3+	404(25.9)	456(34.9)	860(30.0)	
Household size				<0.001
Single	34(2.2)	15(1.1)	49(1.7)	
2-3	245(15.7)	232(17.8)	477(16.6)	
4-8	997(63.9)	889(68.1)	1886(65.8)	
9+	285(18.3)	170(13.0)	455(15.9)	

Source: from the field survey of this study.

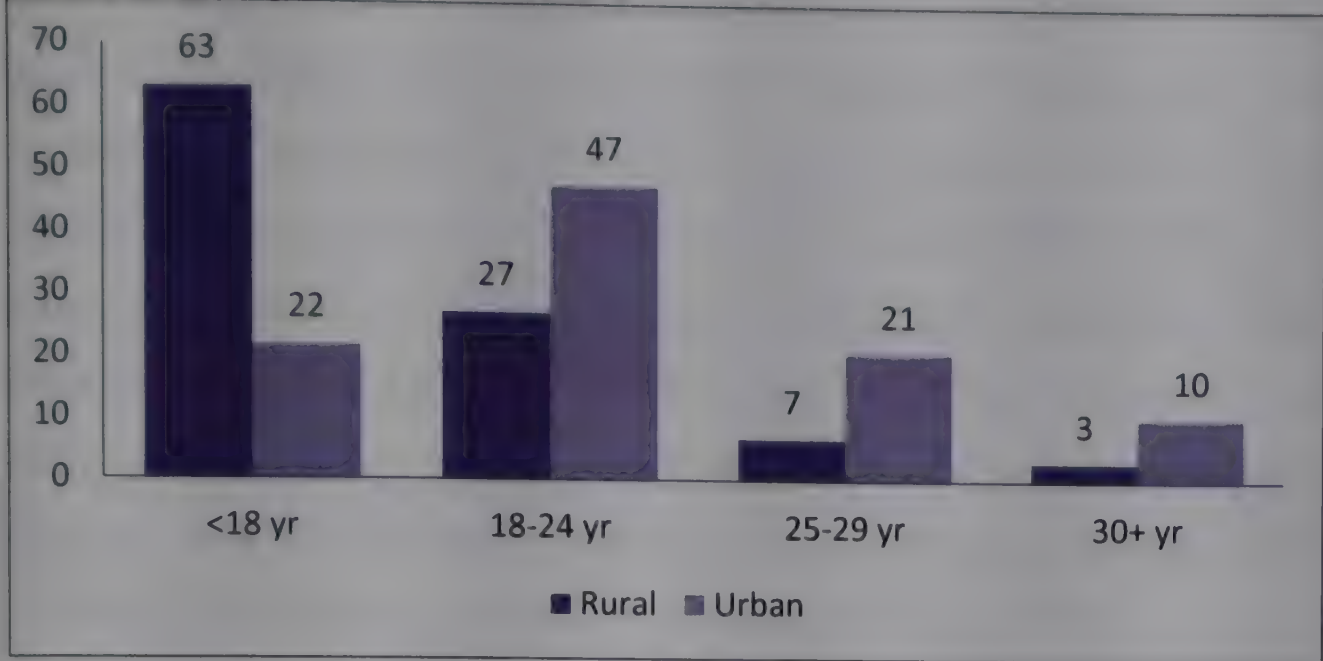
[§]P-value is for χ^2 test of independence comparing the place of residence.

4.2 Sex work profile

Age at sex work debut:

Age at sex work debut specifies the actual age at which she starts sex worker (see Figure 11). Interestingly, more than half (63%) of the rural FSWs have started practicing sex work before attaining the age of 18 years. Contrary to this, among urban FSWs less than a quarter (22%) of urban FSWs has started sex work before 18 years of age. Most (47%) of the urban FSWs have started sex work when they were between 18 to 24 years, and some of them started even later that is between 25 to 29 (21%), and there are also women who have started after crossing 30 years (10%) of age. But about a quarter (27%) of rural FSWs have started sex work between the age of 18 to 25 and very few have started sex work in the age group of 25 to 29 (7%) and 30 and above (3%) years of age. The mean age of sex work debut was 17for rural and 22 for urban FSWs.

Figure 11: Percent distribution of FSWs by age at sex work debut according to place of residence



The qualitative analysis shows that most of the rural women start practicing sex work after attaining menarche. Many rural women in the qualitative interviews said, they were dedicated as *Devadasi*, before or soon after attaining menarche and so that, they entered sex trade at a young age. They also said that there is more demand for young girls in the sex trade business; so families of *Devadasi* women encourage their daughters to start sex work through a ceremony called ‘hennu maduvudu’ or ‘saregu hidisuvudu’ at a very young age.

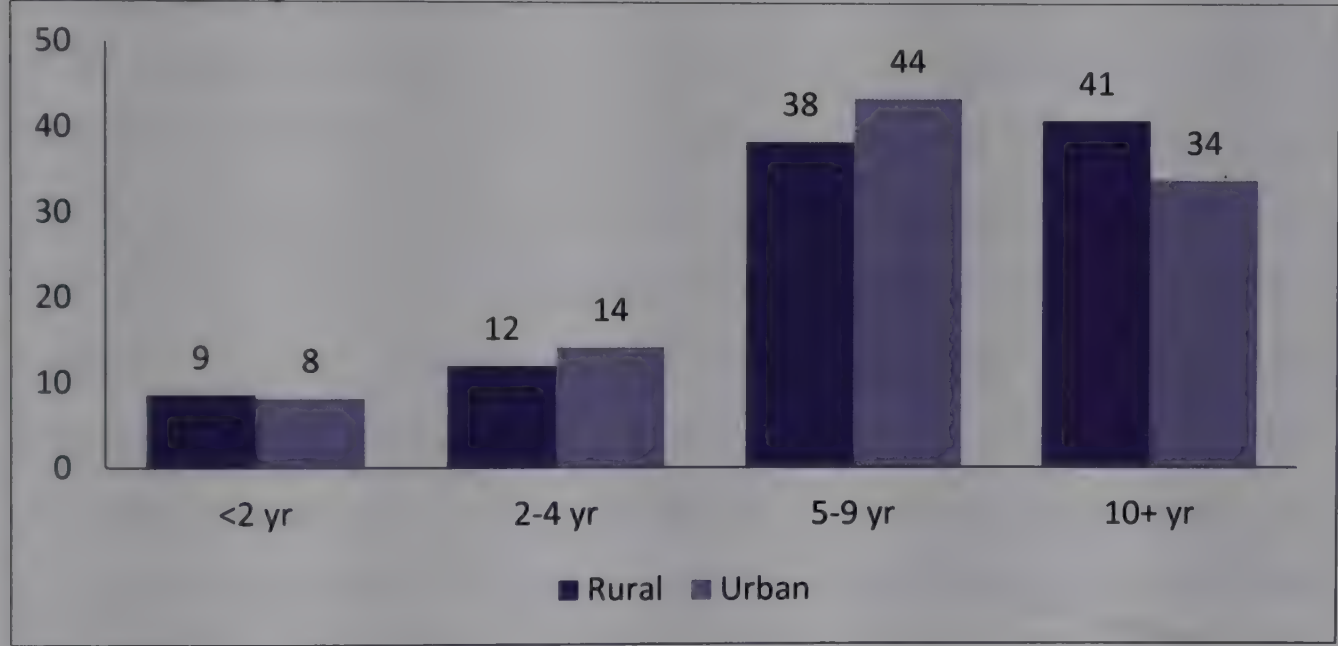
I started dhanda [sex work] when I was 16-year-old...I was made Devadasi when I was six-year-old, and my family encouraged me to start sex work when I was young (Rural FSW, age 23, Bagalkot)

This is somewhat different for the urban non-*Devadasi* women since most of the urban FSWs entered sex work at a different age in different circumstances. One of the women in the qualitative study said, “When my husband was alive my life was going well with my children. After my husband had died, I have to survive and so I started doing dhanda like this” (Urban FSW, age 37, Belgavi).

Duration in sex work:

Duration in sex work is calculated as the difference between current age and the age at which the respondent started sex work. Significantly high proportion of rural FSWs (41%) are in the sex work for more than ten years period compared to urban FSWs (34%). The mean duration of sex work is higher among rural FSWs (10 years) compared to urban FSWs (8 years). Rural FSWs enter sex work at an early age and remain to stay in the profession for the longer duration. But the urban FSWs enter sex work at a later age and stay in the profession for a lesser duration as compared to rural FSWs.

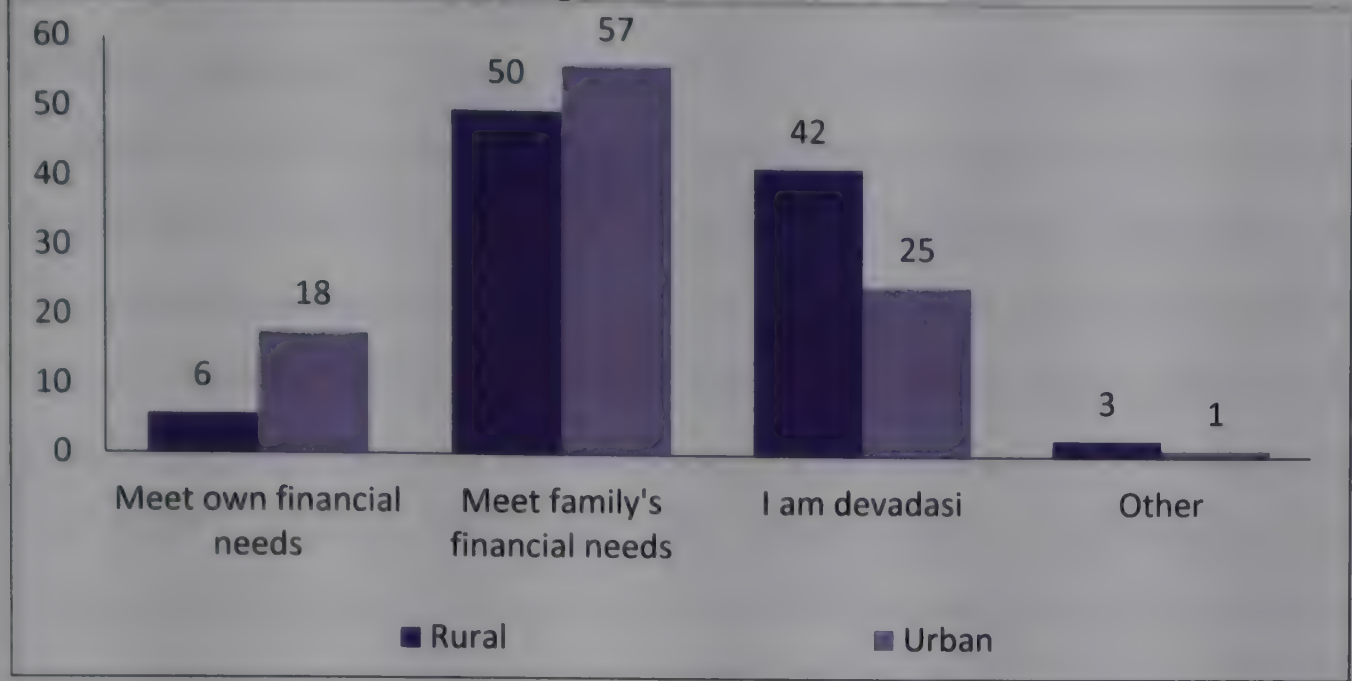
Figure 12: Percent distribution of FSWs by duration in sex work according to place of residence



Reasons for coming into sex work:

There are differences between rural and urban FSWs in reasons for coming into sex work. Almost an equal proportion of rural FSWs reported that family financial need (50%) and initiated into *Devadasi* tradition (42%) was the main reason for coming into sex work. But an around 56% of urban FSWs said, to meet family financial need was a single most reason to enter into the sex trade.

Figure 13: Percent distribution of FSWs by reasons for coming into sex work according to place of residence



Financial needs of the family and *Devadasi* tradition echoed as a prime reason for women entering into sex work. Qualitative analysis of the present research shows a complex set of reasons for women in northern Karnataka to enter sex work as opposed to any one single overriding reason. While abject poverty and *Devadasi* tradition were cited as the main cause by most of the women interviewed, lack of education, lower socio economic status, domestic violence, child marriage, dowry, family debt, alcoholic addiction of the spouse, lack of family support, love affairs, absence of male earning members and harassment and abuse in society and the workplace, were other inter-linked factors facilitating involvement into sex work. Most of the women who initiated into sex work in Bagalkot, Vijayapura and Belagavi district are not forced physically but do so because of the reasons over which had little or no control.

Many rural FSWs said *Devadasi* dedication was one of the prime reasons to enter into sex work. One woman reported, “*I was dedicated as Devadasi when I was young. So now I cannot marry. So I started sex work. Also, family’s financial need has encouraged me to take this path*” (Rural FSW, age 26, Bagalkot). Further analyzes of the

qualitative interviews suggest that child marriage, family debt, and husband's alcoholic behavior led women into the sex trade. One woman reported, *"I got married at the age of fourteen and my husband was 26 at that time. I delivered four children and over time he lost interest in family life, and he became alcoholic. There were no alternatives to run the family and so I started sex work (urban FSW, age 30, Belagavi).* Other women said, *"my family took a huge debt from a garwali, and so I moved Pune to repay the money by practicing sex work"* (Rural FSW, age 24, Vijayapura). Harassment and violence perpetrated by spouses for dowry created other problems. One woman narrated how she had been subjected to violence for the reason of dowry.

"My husband was asking me to bring fifty thousand from my parents, but they are poor and can't afford such a big amount. As I knew the fact I did not tell my parents but silently bared the pain...he harassed me physically. My husband sent me to parent's home... not allowed me to live with him...later no support from parents as well and entered this profession (urban FSW, age 31, Belagavi).

Love affairs and lack of family support were another reason for few women to enter sex work. Urban women from Belagavi district stated how her love affairs at the young age lead her to enter sex work.

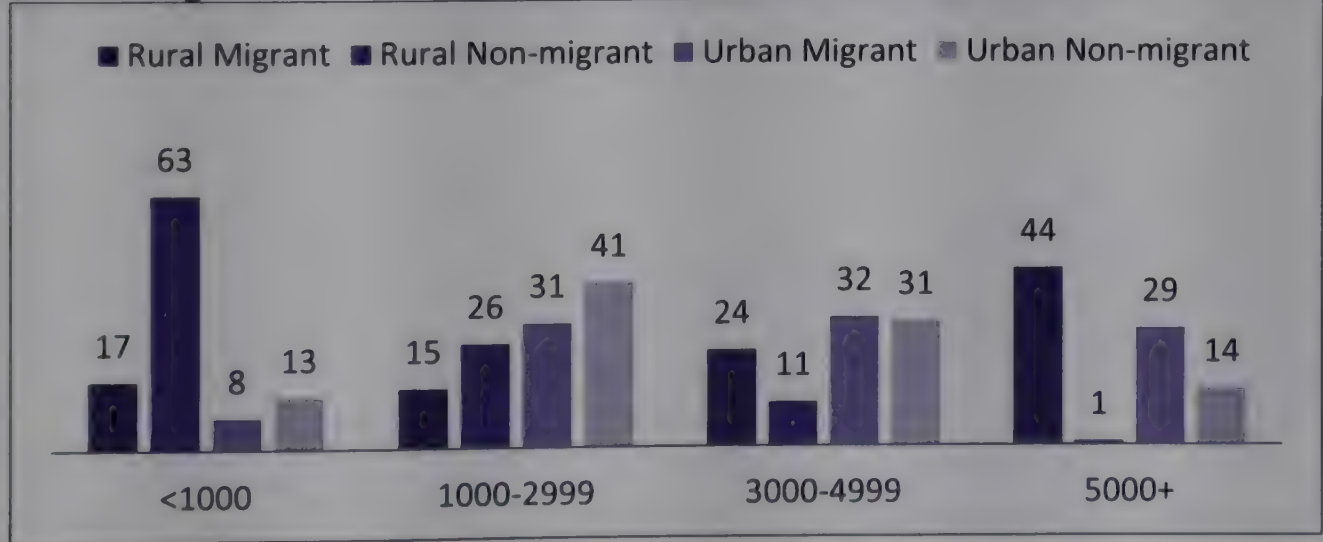
"I was in love with a guy before I could reach menarche... but my parents suddenly decided to get me married as I started opposing I faced physical violence, and forcibly they arranged my marriage with another person. I was in that relationship for hardly a week, I clearly explained them about my intention and separated from that relationship...by the time I was out of all the tensions and turmoils, I approached my boyfriend... he was

not able to convince his parents to marry me, and he got married to another girl. This incident made a huge impact in my life I attempted suicide as I decided to put a full stop to all the worries and failure fortunately or, unfortunately, I was hospitalized and saved... Later on, I was posed with a new turn and people started approaching me for sex slowly... I entered sex work” (Urban FSW, age 27, Belagavi).

Income and other work apart from sex work:

Variations are found in the monthly household income of the rural and urban FSWs. Significantly high proportion (77%) of urban FSWs have a monthly income of more than 5000 rupees. Whereas, only 45% rural FSWs have a monthly income of more than 5000 rupees. Similarly, significantly high proportion of urban FSWs earn more income from sex work as compared to rural FSWs. But when we further analyzed the earning from sex work by mobility status of rural and urban FSWs, rural migrant FSWs earn more money from sex work than anybody else. More than 43% of rural migrant earn more than 5000 rupees in a month compared to rural non-migrant (0.5%), urban migrant (29.3%) and urban non-migrant (14.4%) FSWs from study districts.

Figure 14: Percent distribution of FSWs by Income from sex work according to their mobility status



Further qualitative analysis indicates that both rural and urban migrant FSWs earn more and also, both of them share half of the income with other people such as brothel madams, middleman, pimps, and police. Also, migrant women have more expenditure compared to local women for their food, travel and on cosmetics and clothes, which are essential to attracting their urban clients. One of the rural migrant women explained her finance management system with brothel madam in the brothels she works at a different destination.

We earn an average 5000 per month...account will be maintained with garwali. Garwali will give different colored tokens for each women working in her brothel. One token is equal to 50 rupees, and daily each woman put those token into their respective box, and it depends on their day-to-day client volume. This account maintained at garwali level, and the accounts will be settled in front of us on every month (rural FSW, age 32, Bagalkot).

There is also a difference in the contribution of earning from sex work to the household income. Among rural FSWs, 65% contribute all of their income and 32% contribute more than half of their earning from sex work to the household income. Whereas, 47% of urban FSWs contribute all, and the 50% contribute more than half of their earning from sex work to the household income.

Table 9: Percent distribution of FSWs by source of income according to place of residence

	Rural N=1561 (%)	Urban N=1306 (%)	Total N=2867 (%)	P[§]
Monthly household income				<0.001
<2000	264(16.9)	1(0.1)	265(9.2)	
2000-4999	590(37.8)	297(22.7)	887(30.9)	
5000-9999	492(31.5)	789(60.4)	1281(44.7)	
10000+	215(13.8)	219(16.8)	434(15.1)	
Monthly income from sex work				<0.001
<1000	597(38.2)	139(10.6)	736(25.7)	
1000-2999	320(20.5)	478(36.6)	798(27.8)	
3000-4999	277(17.7)	414(31.7)	691(24.1)	
5000+	367(23.5)	275(21.1)	642(22.4)	
Earnings from sex work contributed to household income				<0.001
All	1022(65.5)	619(47.4)	1641(57.2)	
More than half	495(31.7)	656(50.2)	1151(40.1)	
Less than half	42(2.7)	31(2.4)	73(2.5)	
Does someone else contribute to household income				0.682
No	280(17.9)	242(18.5)	522(18.2)	
Yes	1281(82.1)	1064(81.5)	2345(81.8)	
Who contributes to household income				<0.001
Lover	521(44.0)	376(35.4)	897(39.9)	
Husband	54(4.6)	163(15.3)	217(9.6)	
Father	214(18.1)	162(15.2)	376(16.7)	
Brother	597(50.4)	377(35.3)	974(43.3)	
Mother	359(30.3)	268(25.2)	627(27.9)	
Other	0(0.0)	295(27.7)	295(13.1)	
Any other work apart from sex work				<0.001
No	866(55.5)	533(40.8)	1399(48.8)	
Yes	691(44.3)	773(59.2)	1464(51.1)	

Source: from the field survey of this study.

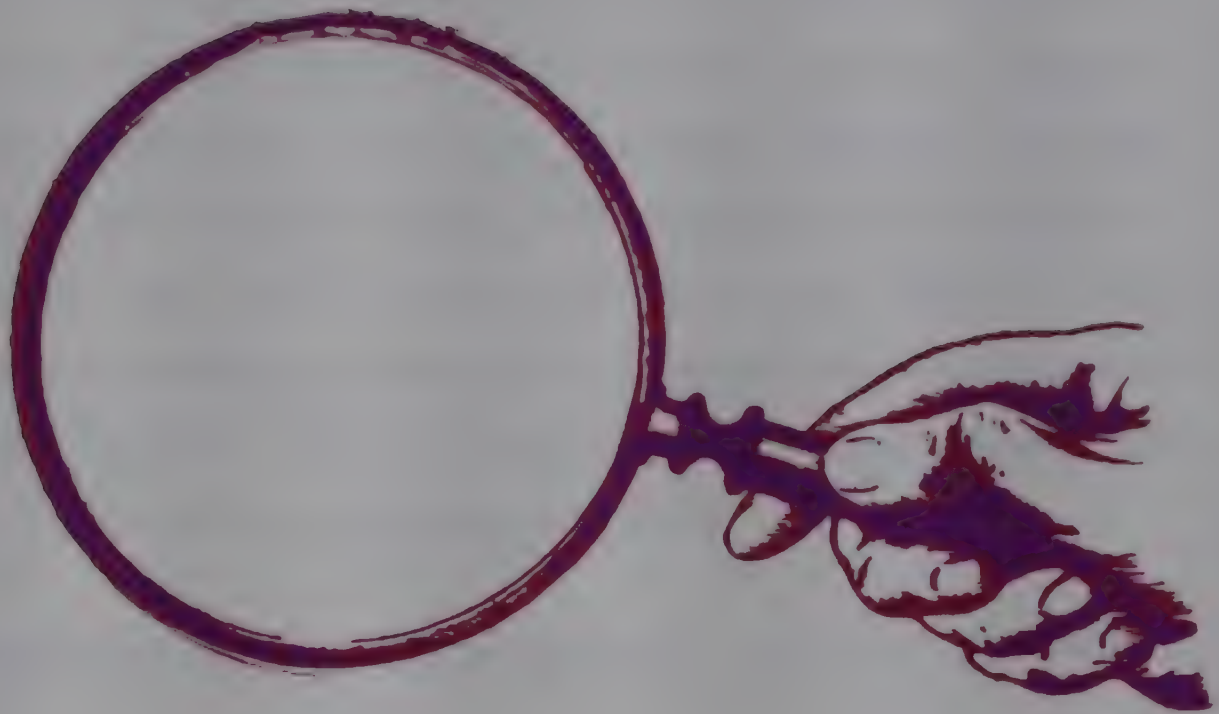
[§]P-value is for χ^2 test of independence comparing the place of residence.

Both rural and urban FSWs have the contribution from someone else for their family income. Brother, lover, and mother are the top three contributors to the rural FSWs' household income and lover, brother and others are the top three contributors to urban FSWs household income. Significantly higher proportion of urban FSWs

(59%) does other work apart from sex work, compared to rural FSWs (44%).

The reasons for involving in another work apart from sex work is that it will help them to keep their anonymity in sex work, and other people in the society will not look down upon them. Also, this will be an additional income source apart from sex work. There is uncertainty about income from sex work concerning stable earnings, and the other work provides cushioning to fall back on.

CHAPTER-5



MIGRATION/MOBILITY PATTERNS AND PREDICTORS OF OUT MIGRATION

CHAPTER 5

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This chapter presents findings for the research objectives two, and three, and intends to compare migration and mobility patterns and predictors for the out migration of FSWs from Bagalkot, Vijayapura and Belgaum districts in northern Karnataka. Findings from both quantitative and qualitative study were presented in this chapter and comparisons were made between rural and urban FSWs on their migration and mobility patterns. Also, findings were presented on an association between the individual, structural, environmental and cultural factors and the out-migration of FSWs.

5.1 Migration and mobility patterns of rural and urban FSWs

Rural and urban respondents were asked to list all the places they have visited in one year prior to the survey. Table 10 lists all the destination places in the state, district and taluka level which were mentioned by at least 1% of the FSWs. However, to have a comprehensive view of all the destinations, the total number of destinations mentioned by rural and urban FSWs has been provided. The mobility pattern of both rural and urban FSWs by the district of origin (Belagavi, Bagalkot, and Vijayapura) have also been looked into in Table 10, and this describes the volume of mobility from each specific source districts to the particular destinations. It should be noted that both migrant and mobile FSWs were included in the analysis to make inferences about the migration and mobility patterns of rural and urban FSWs.

More than half (53%) of the FSWs from Belagavi, Bagalkot and Vijayapura districts tend to travel within the state of Karnataka, and

less than a half (47%) travel to places in the neighboring state of Maharashtra. Rural FSWs (76%) visit Maharashtra more and among urban FSWs, most of them (95%), travel within the district or state for sex work. A very few portion of rural and urban FSWs have also reported visiting Goa (0.6%) for sex work. The most common destinations for rural FSWs are Pune (23%), Sangli (19%) and Mumbai (15%) in Maharashtra and for the urban FSWs, Belagavi (59%), Bagalkot (20%) and Vijayapura (14%) are the top three destinations.

Table 10: Percent distribution of FSWs by main destination according to place of residence

Destination	Rural N= 833 (%)	Urban N= 584 (%)	Total N=1417 (%)	P ^s
State				<0.001
Karnataka	190 (22.8)	558 (95.5)	748 (52.8)	
Maharashtra	635 (76.2)	25 (4.3)	660 (46.6)	
Goa	8 (1.0)	1 (0.2)	9 (0.6)	
District				<0.001
Belagavi	106 (12.7)	342 (58.6)	448 (31.6)	
Bagalkot	55 (6.6)	116 (19.9)	171 (12.1)	
Vijayapura	21 (2.5)	81 (13.9)	102 (7.2)	
Mumbai	124 (14.9)	4 (0.7)	128 (9.0)	
Kolhapura	40 (4.8)	3 (0.5)	43 (3.0)	
Pune	191 (22.9)	6 (1)	197 (13.9)	
Sangli	162 (19.4)	10 (1.7)	172 (12.1)	
Satara	27 (3.2)	2 (0.3)	29 (2.0)	
Thane	81 (9.7)	1 (0.2)	82 (5.8)	
Goa	9 (1.1)	1 (0.2)	10 (0.7)	
Other	17 (2.0)	18 (3.1)	35 (2.5)	
Taluka				<0.001
Belagavi	9 (1.1)	46 (7.9)	55 (3.9)	
Athani	6 (0.7)	28 (4.8)	34 (2.4)	
Bailhongal	0 (0.0)	20 (3.4)	20 (1.4)	
Ramdurga	9 (1.1)	21 (3.6)	30 (2.1)	
Savadatti	6 (0.7)	38 (6.5)	44 (3.1)	
Raybag	7 (0.8)	37 (6.3)	44 (3.1)	

Chikodi	29 (3.5)	47 (8.0)	76 (5.4)
Gogak	17 (2.0)	66 (11.3)	83 (5.9)
Hukkeri	5 (0.6)	19 (3.3)	24 (1.7)
Jamkhandi	52 (6.2)	106 (18.2)	158 (11.2)
Mudhol	13 (1.6)	18 (3.1)	31 (2.2)
Badami	1 (0.1)	9 (1.5)	10 (0.7)
Vijayapura	10 (1.2)	48 (8.2)	58 (4.1)
Indi	0 (0.0)	13 (2.2)	13 (0.9)
Muddebihal	9 (1.1)	13 (2.2)	22 (1.6)
Hubli	0 (0.0)	10 (1.7)	10 (0.7)
Bhiwandi	78 (9.4)	1 (0.2)	79 (5.6)
Mumbai	124 (14.9)	4 (0.7)	128 (9.0)
Pune	191 (22.9)	6 (1.0)	197 (13.9)
Karad	27 (3.2)	2 (0.3)	29 (2.0)
Kolhapur	39 (4.7)	3 (0.5)	42 (3.0)
Sangli	119 (14.3)	7 (1.2)	126 (8.9)
Miraj	43 (5.2)	3 (0.5)	46 (3.2)
Other	39 (4.7)	19 (3.3)	58 (4.1)

Source: from the field survey of this study.

[§]P-value is for χ^2 test of independence comparing the place of residence.

However, there are important differences in mobility patterns and the volume of FSWs migration/mobility by districts. The below figure 15 and table 12 illustrate the rural and urban FSWs mobility pattern and volume from each specific source district to the different destinations within Karnataka and Maharashtra.

A significant proportion of rural FSWs from Belagavi district visit different destinations in Maharashtra, which includes: Sangli (22%), Pune (15%) and Mumbai (11%) followed by Kolhapur (5%) and Goa (4%). Also a significant proportion (40%) of rural FSWs from Belagavi district move around different towns within District. But in contrast, very less proportion of urban FSWs from Belagavi district visits destinations in Maharashtra and majority (91%) of them visit different taluka places within the district. The places which urban FSWs visits includes: Gogak (18%), Belagavi (13%), Chikodi (13%),

Saudatti (11%), Raybag (10%), Athani (8%), Bailhongal (6%), Ramdurga (6%) and Hukkeri (5%).

Rural FSWs from Bagalkot district are concentrated in Pune (26%), Sangli (23%), Bhiwandi (13%), Mumbai (12%) followed with Kolhapur (5%) and Satara (5%). But most (90%) of the urban FSWs from Bagalkot district move around two major taluka places within the district, which is Jamkhandi (70%) and Mudhol (11%).

Similarly, rural FSWs from Vijayapura district go to Mumbai (34%), Pune (25%) and Bhiwandi (12%) in Maharashtra state. But the majority (94%) of urban FSWs from Vijayapura district moves around three major taluka places within the district which includes: Vijayapura (52%), Muddebihal (16%) and Indi (16%).

Compared to urban FSWs, rural women tend to move more number of destinations (rural 57 and Urban 51) in a stipulated period. Particularly the women from Belagavi district tend to migrate more number of destinations (rural 37, urban 30). This might be partly because Belagavi district is a bigger area and shares a long border with Maharashtra state and its geographical proximity with Goa. The district wise variations of rural FSWs might be indicative of the networks regulating the migration of FSWs from Northern Karnataka to Southern Maharashtra.

The research also attempts to explain those people involved in the network and how it operates while sending girls to different destinations for sex work. According to this data, whenever an FSW wants to leave the village to work in some other place, she and/or her family get in touch with other FSWs in the village or area who have been practicing sex work outside the village. One woman reported,

“My mother approached one of her friend’s daughter who works in Pune, and she helped me to move to Pune initially” (Rural FSW, age 23, Bagalkot). In other situations, senior FSWs working in brothels in various places act as brokers or agents and encourage FSWs and/or their families to come and work in the same brothel, often receiving a commission from the brothel madam. As a result, FSWs from the same village/area tend to go to the same place of destination and even the same brothel or sex work setting. One rural migrant woman reported;

Aakka [sister/woman] from our village used to meet my mother frequently, and she would visit our house whenever she came home. She only encouraged my mother to send me with her. I accompanied her to Bhiwandi after one of her visit to our village for a Jatra, and I was staying with her in the same Garwali’s house. (Rural FSW, age 27, Vijayapura).

Also in some situations, brothel madams are directly involved in recruiting girls from different villages. Brothel madams frequently visit villages and identify potential families and brothel madam’s families in the native village assist them in this process. Later, brothel madams motivate girl’s parents by explaining the possibility of making money and also offer huge money as a loan to the girl’s families. One rural woman said:

Our parents do not think before taking a loan from brothel madam. They even don’t check the interest rates. Mother took 50000 loans from Kashavva [brothel madam] and sent me along with her to Sangli. It took five years for me to repay the loan. (Rural FSW, age 34, Bagalkot).

In the qualitative study, many women said, they were aware of the purpose of their visit to destinations, and it took place in consultation with family members. In some cases, family member accompanied the women during their first visit to the destination. But few women were not aware of the purpose of their visit and said, they were shocked when they realized that they came for sex work. Some of them also said they went to those places to support their sister or aunt in preparing food and other household chores. But slowly they were pulled into the profession. One woman said:

They [family members] take money from Gharwali...without telling us anything; then they send us... after this only I came to know that my parents have taken money from Gharwali and sent me to do dhanda. (Rural FSW, Age 18, Bagalkot).

Circumstance seems to be different for urban FSWs. Considering their different marital status, urban FSWs are not particularly interested in traveling to long distance place for the longer duration. Also, they are keen to preserve their anonymity, so they frequently change their place of visit for sex work. Also few urban FSWs said, they entered sex work at a later age and considering their age, they found less demand in the destinations where more young rural girls are prominent. Also, brothel madams prefer to have young girls rather than middle-aged women, who have entered into sex work late. Also, families of urban FSWs are less frequently involved in sex trade business.

Figure 15: Main destinations for rural and urban FSWs in one year prior to survey

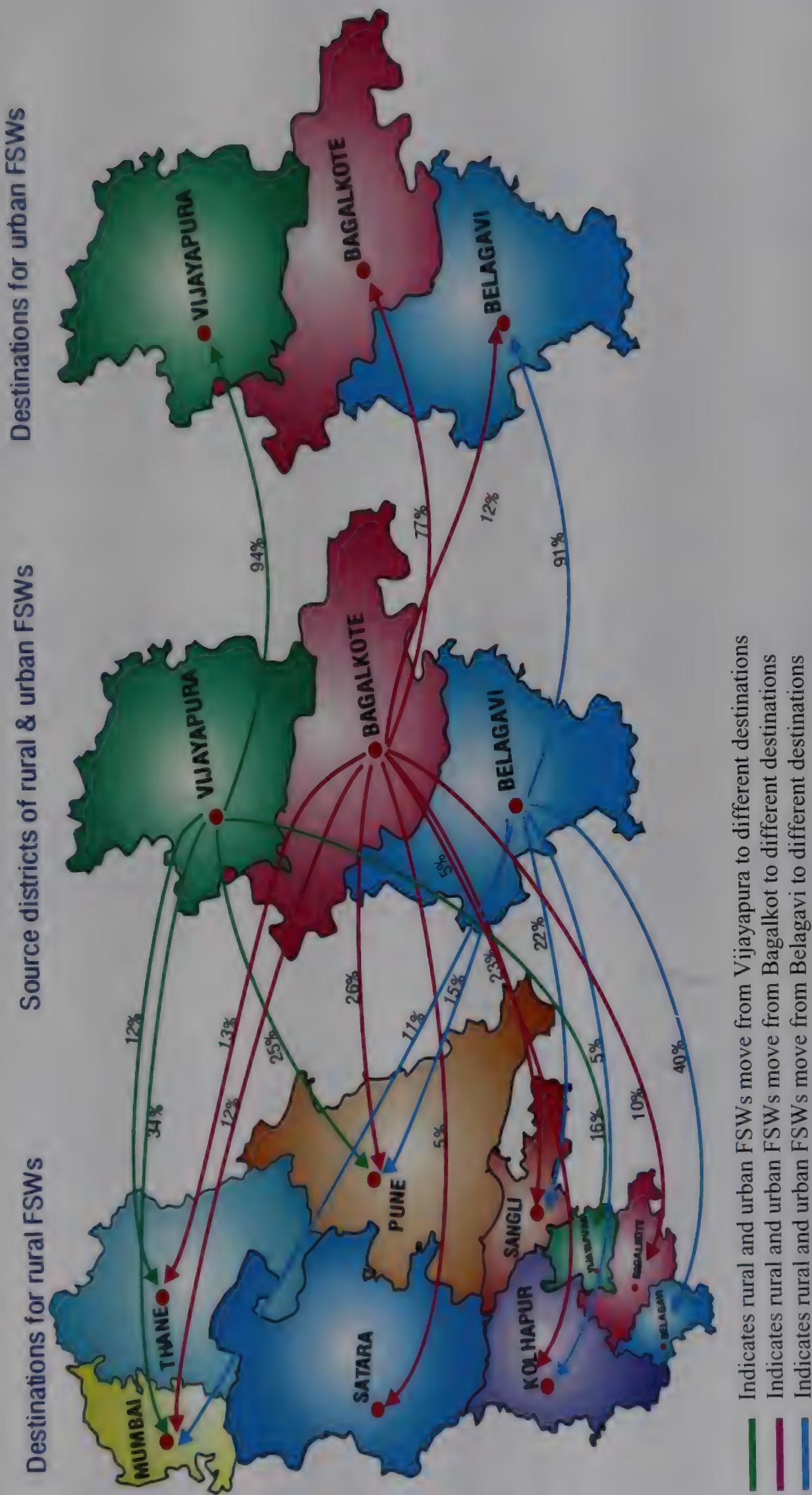


Table 11 Main destinations for rural and urban FSWs in one year prior to survey

Destination	Rural			Urban		
	Belagavi N=216 (%)	Bagalkot N=491 (%)	Vijayapura N=126 (%)	Belagavi N=356 (%)	Bagalkot N=148 (%)	Vijayapura N=80 (%)
State						
Karnataka	92 (42.6)	70 (14.30)	28 (22.2)	347 (97.5)	134 (90.5)	77 (96.2)
Maharashtra	117 (54.2)	421 (85.7)	97 (77)	9 (2.5)	14 (9.5)	2 (2.5)
Goa	7 (3.2)	0 (0.0)	1 (0.8)	0 (0.0)	0 (0.0)	1 (1.3)
Districts						
Belagavi	85 (39.4)	20 (4.1)	1 (0.8)	324 (91)	18 (12.2)	0 (0.0)
Bagalkot	4 (1.9)	49 (10.0)	2 (1.6)	2 (0.6)	114 (77.0)	0 (0.0)
Vijayapura	0 (0.0)	1 (0.2)	20 (15.9)	6 (1.7)	0 (0.0)	75 (93.8)
Mumbai	23 (10.6)	59 (12.0)	42 (33.3)	0 (0.0)	2 (1.4)	2 (2.5)
Kolhapur	11 (5.1)	26 (5.3)	3 (2.4)	3 (0.8)	0 (0.0)	0 (0.0)
Pune	32 (14.8)	128 (26.1)	31 (24.6)	0 (0.0)	6 (4.1)	0 (0.0)
Sangli	48 (22.2)	113 (23.0)	1 (0.8)	5 (1.4)	5 (3.4)	0 (0.0)
Satara	0 (0.0)	24 (4.9)	3 (2.4)	1 (0.3)	1 (0.7)	0 (0.0)
Thane	1 (0.5)	65 (13.2)	15 (11.9)	0 (0.0)	1 (0.7)	0 (0.0)
Goa	8 (3.7)	0 (0.0)	1 (0.8)	0 (0.0)	0 (0.0)	1 (1.3)
Other	4 (1.9)	6 1.2)	7 (5.6)	15 (4.2)	1 (0.7)	2 (2.5)
Taluka						
Belgavi	9 (4.2)	0 (0.0)	0 (0)	46 (12.9)	0 (0.0)	0 (0.0)
Athani	5 (2.3)	0 (0.0)	1 (0.8)	28 (7.9)	0 (0.0)	0 (0.0)

Bailhongal	0 (0.0)	0 (0.0)	0 (0)	20 (5.6)	0 (0.0)	0 (0.0)
Chikodi	29 (13.4)	0 (0.0)	0 (0)	47 (13.2)	0 (0.0)	0 (0.0)
Gokak	11 (5.1)	6 (1.2)	0 (0)	66 (18.5)	0 (0.0)	0 (0.0)
Hukkeri	5 (2.3)	0 (0.0)	0 (0.0)	19 (5.3)	0 (0.0)	0 (0.0)
Rabag	7 (3.2)	0 (0.0)	0 (0.0)	37 (10.4)	0 (0.0)	0 (0.0)
Savadatti	6 (2.8)	0 (0.0)	0 (0.0)	38 (10.7)	0 (0.0)	0 (0.0)
Ramdurga	8 (3.7)	1 (0.2)	0 (0.0)	21 (5.9)	0 (0.0)	0 (0.0)
Jamkhandi	3 (1.4)	49 (10.0)	0 (0.0)	2 (0.6)	104 (70.3)	0 (0.0)
Mudhol	0 (0.0)	13 (2.6)	0 (0.0)	1 (0.3)	17 (11.5)	0 (0.0)
Badami	1 (0.5)	0 (0.0)	0 (0.0)	0 (0.0)	9 (6.1)	0 (0.0)
Vijayapura	0 (0.0)	1 (0.2)	9 (7.1)	6 (1.7)	0 (0.0)	42 (52.5)
Indi	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	13 (16.3)
Muddebihal	0 (0.0)	0 (0.0)	9 (7.1)	0 (0.0)	0 (0.0)	13 (16.3)
Hubli	0 (0.0)	0 (0.0)	0 (0.0)	10 (2.8)	0 (0.0)	0 (0.0)
Sangli	27 (12.5)	92 (18.7)	0 (0.0)	2 (0.6)	5 (3.4)	0 (0.0)
Miraj	21 (9.7)	21 (4.3)	1 (0.8)	3 (0.8)	0 (0.0)	0 (0.0)
Bhiwandi	1 (0.0)	62 (12.6)	15 (11.9)	0 (0.0)	1 (0.7)	0 (0.0)
Mumbai	23 (10.6)	59 (12.0)	42 (33.3)	0 (0.0)	2 (1.4)	2 (2.5)
Pune	32 (14.8)	128 (26.1)	31 (24.6)	0 (0.0)	6 (4.1)	0 (0.0)
Karad	0 (0.0)	24 (4.9)	3 (2.4)	1 (0.3)	1 (0.7)	0 (0.0)
Kolhapur	10 (4.6)	26 (5.3)	3 (2.4)	3 (0.8)	0 (0.0)	0 (0.0)
Other	18 (8.3)	9 (1.8)	12 (9.5)	6 (1.7)	3 (2.0)	10 (12.5)

Source: from the field survey of this study.

The difference between rural and urban FSWs extends beyond the fact they go to different places (table 12 below). The frequency and duration of movement is based on the data related to the last place of destination. Rural FSWs go on an average one place per year (mean 1.58) for about 11 times every year (mean 11) and stay for about 124 days for each visit (mean 124). On the other hand, urban FSWs go an average two places every year (mean 1.94) but visit quite frequently (mean 66) for a relatively short period (mean days 16). Hence, rural FSWs spend a little time in the village, taking long trips to the same places, but urban FSWs split their time between the village and other places of destination. The trips are frequent and tend to be short in duration for urban FSWs.

Table 12: Percent distribution of FSWs by frequency of visit and duration of stay in different destinations according to place of residence

Characteristic	Rural N= 833	Urban N= 584	Total N=1417
Mean number of places visited in the last one year	1.58	1.94	1.74
Mean number of visits per year to the last place of destination			
Mean	11	66	34
Mean duration of stay at the last place of destination (in days)			
Mean	124	16	80

Source: from the field survey of this study.

Respondents asked the age at which they first visited the last destination and the person who made the decision for the first and subsequent visits to the most recent destination to understand the decision-making process related to destinations visit. The mean age of the rural FSWs when they first visited the last destination was 20 and whereas it was 26 for the urban FSWs. This indicates that rural FSWs have first visited the last destination at quite a young age

compared to urban FSWs. More than half of the rural FSWs have first visited the last destination deciding on their own and also a quarter of their decisions were taken by their family members. But this is slightly different for urban FSWs and almost an equal proportion of urban FSWs first visit to the last destinations were decided on their own (39%) and also because of friends (38%) respectively. Also, an important proportion (14%) of urban FSWs first destination visits were decided by their clients.

Unlike in the case of the first visit, at present most of the rural (95%) and urban (92%) FSWs move to various places as a result of their own decision. Also, a small proportion of friends (4%) still decide the place to move for urban FSWs. A small proportion of rural (3%) and urban (2%) women go to various places at the request of their clients who are possibly their regular clients.

Table 13: Percent distribution of FSWs by age at first sex and decisions to move last destination according to place of residence

Characteristic	Rural N= 833 (%)	Urban N= 584 (%)	Total N=1417 (%)	P ^s
Age when first time visited this place				<0.001
12-18	342 (41.0)	61 (10.4)	403 (28.4)	
19-25	351(42.1)	263(45.0)	614(43.3)	
25+	140(16.8)	260(44.5)	400(28.2)	
Mean age	20	26	23	
Person who made the decision for the first visit to the last destination				<0.001
Own decision	458(55.0)	227(38.9)	685(48.3)	
Family	179(21.5)	51(8.7)	230(16.2)	
Friends	128(15.4)	219(37.5)	347(24.5)	
Client	36(4.3)	81(13.9)	117(8.3)	
Pimp/lover/other	32 (3.8)	6 (1.0)	38 (2.6)	

Currently, who decides to visit the last destination				<0.001
Own decision	791(95)	535(91.6)	1326(93.6)	
Family	12(1.4)	15(2.6)	27(1.9)	
Friends	5(0.6)	25(4.3)	30(2.1)	
Client	21(2.5)	8(1.5)	29(2.0)	
Pimp/lover/other	4 (0.5)	1 (0.1)	5 (0.3)	

Source: from the field survey of this study.

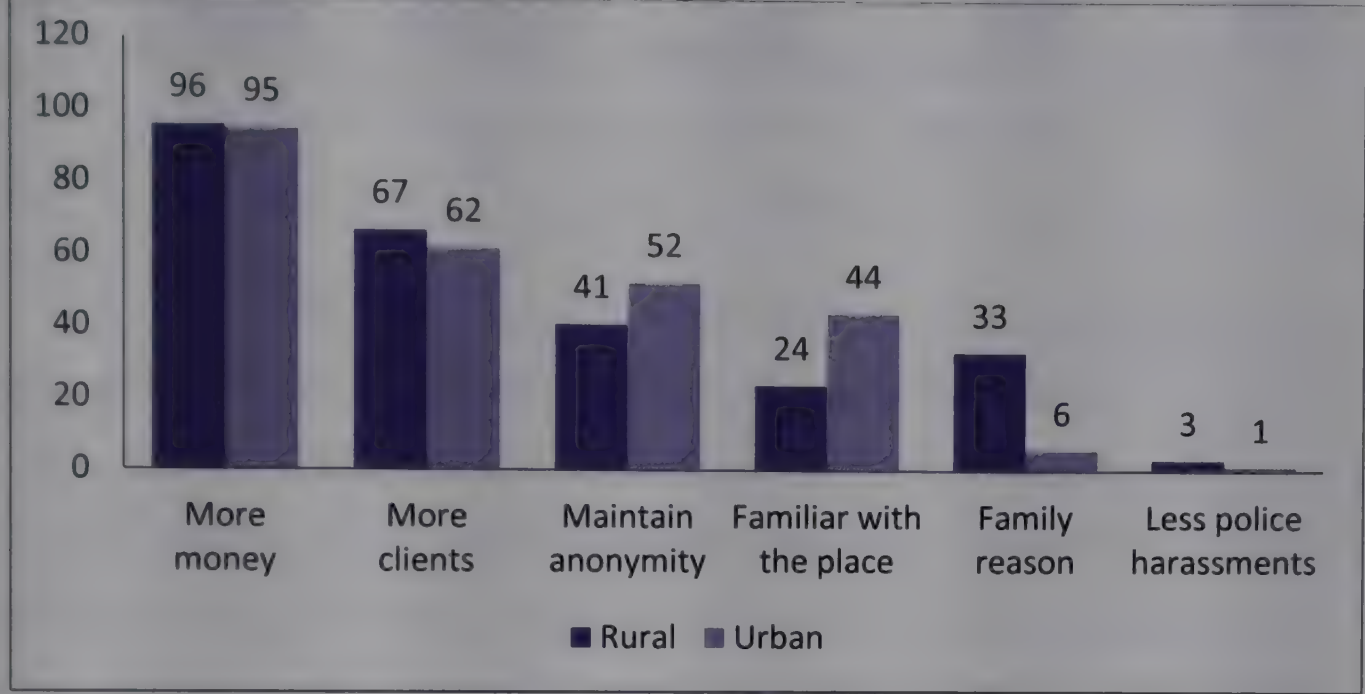
[§]P-value is for χ^2 test of independence comparing the place of residence.

As stated earlier, a significant proportion of rural FSWs are *Devadasis* and usually initiated into sex work as a result of their families' initiative. The rural FSWs also live in an environment where they get aware about particular destinations through their interaction with former and current migrant FSWs. Also, an established network from destination to their source villages helps them to decide the destinations on their own. Given this background, it is believed that women from rural areas in northern Karnataka are sent by their families to brothels in southern Maharashtra. Whereas this is different for urban FSWs since most of them are non-*Devadasis*, and their first visit to the last destination was decided on their own or guided by friends or clients.

To better understand the determinants of FSWs' migration/mobility, different reasons to visit the last place of destination were asked (picture 16). The Economic reason is the prime reason and about 96% of rural and 95% of urban FSWs have visited the last destination in the past one year to make more money. They have also said that they get significantly more number of clients (rural 67% & urban 62%) in the last place of visit compared to their village/town. Nearly half of the rural (41%) and more than half of the urban (52%) FSWs work in other locations because they do not want people in their village/town to know that they are doing sex work. The family was another reason (33%) for rural FSWs to visit the last

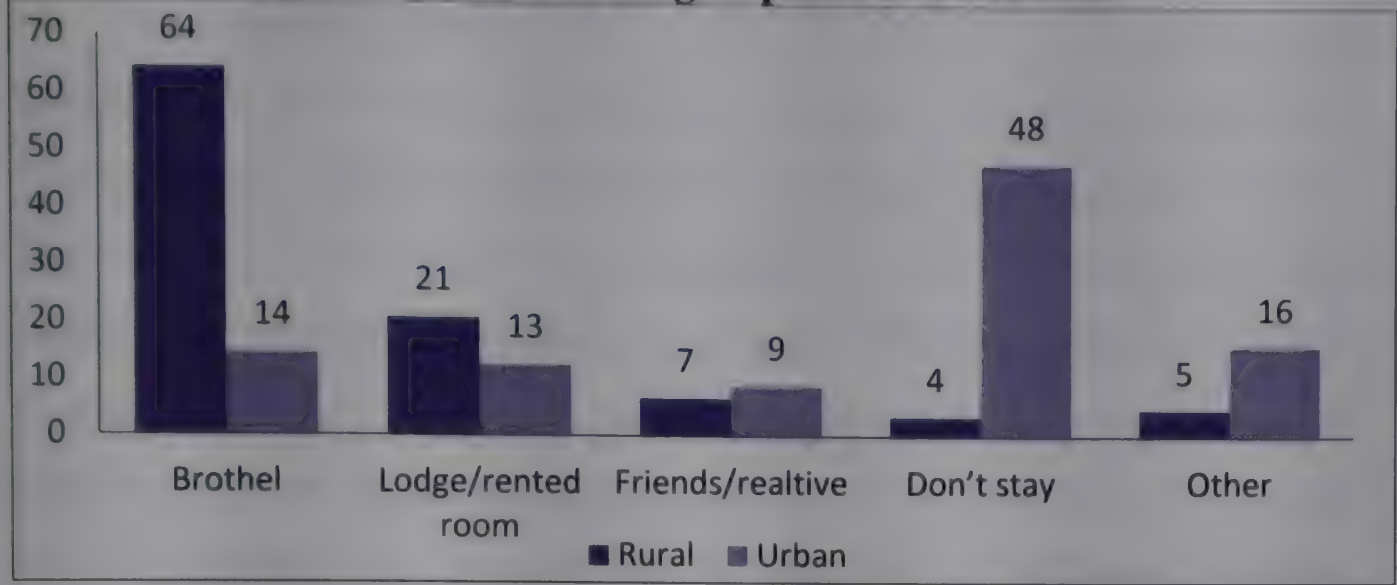
place and it means, an established family network in these places have guided the rural women to visit these particular destinations. Familiarity with the place was another reason for urban FSWs (44%) to visit the last place of destination.

Figure 16: Percent distribution of FSWs by reasons for visit last place of destination according to place of residence



Significant proportions of rural FSWs stays overnight and have accommodation arrangements in the destinations when they go for sex work. The large majorities of rural FSWs stay in brothels (64%) or lodge/rented rooms (21%). On other hands, nearly half (48%) of the urban FSWs don't stay in the places they visit for sex work, and this is because they go to the nearby towns for the day in the morning, have a few clients and come back home in the evening. But the remaining half of the urban FSWs have a variety of arrangements, from staying in the brothel (14%), lodge/rented room (13%) and with friends/relatives (9%).

Figure 17: Percent distribution of FSWs by place of stay at the last place of destination according to place of residence



In the interviews, many women have spoken about difficulties and situations they come across when they stay in brothels at different destinations. Brothels are controlled by brothel madams, and the brothel madam takes many decisions for girls including the decision about the type of clothes they can wear, the food they prepare every day, places women can visit or not, people women can meet or not, etc. Women practice sex work and stay in the brothels, and they pay a certain part of their income to the brothel madams for their accommodation and food. Most of the time they prepare food in the brothel and also, sometimes they prefer to eat outside.

5.2 Predictors of outmigration:

This section presents the results of bivariate and multivariate analyses related to the out-migration among rural and urban FSWs. The outcome variable of interest is a likelihood of migration (Yes=1; No=0). The predictors of out-migration were grouped into four categories, namely, individual, structural, environmental and cultural factors. Individual factors include the participant's age, the number of children, age at marriage, literacy, the level of education. Contextual factors include age at initiation of sex work, languages spoken, *Devadasi* status, place of solicitation, client volume, income from sex work and other sources. Environmental factors include mobility status, household size, other contributors to family income and number of living children. The cultural factors include respondent's religion, caste, languages spoken, marital status and being *Devadasi*. Both mobile and migrant FSWs were categorized as migrants and the characteristics that have previously associated with migration in other studies or characteristics that remain significantly associated with migration (at $p < 0.05$) were retained in the final model for multivariate analysis.

Table 14 presents the bivariate association between predictors and outcome of interest. Associations significant at 5% level of significance are described in the below section. Table 17 depicts the results of the multivariate analysis in the form of adjusted odds ratio (AOR). Both bivariate and multivariate analyses are done separately for the rural and urban FSWs.

Table 14: Results of bivariate analysis showing association between individual, structural, environmental and cultural factors with FSWs mobility status

Characteristics	Rural		P [§]	Urban		P [§]
	Non migrant n=728 (%)	Migrant n=833 (%)		Non migrant n=722 (%)	Migrant n=584 (%)	
Residence			0.036			0.075
Belagavi	221(50.6)	216(49.4)		396(52.7)	356(47.3)	
Bagalkot	382(43.8)	491(56.2)		205(58.1)	148(41.9)	
Vijayapura	125(49.8)	126(50.2)		121(60.2)	80(39.8)	
Current age			<0.001			0.023
<25 years	264(36.2)	466(63.8)		118(50.4)	116(49.6)	
25-29 years	134(54.0)	114(46.0)		163(51.1)	156(48.9)	
30-34 years	131(51.0)	126(49.0)		199(56.1)	156(43.9)	
35+ years	199(61.0)	127(39.0)		242(60.8)	156(39.2)	
Literacy status			0.936			0.125
Illiterate	587(46.6)	673(53.4)		482(53.9)	413(46.1)	
Literate	141(46.8)	160(53.2)		240(58.4)	171(41.6)	
Number of languages speak			<0.001			<0.001
1	398(72.2)	153(27.8)		434(59.7)	293(40.3)	
2	226(36.2)	399(63.8)		191(54.0)	163(46.0)	
3+	104(27.0)	281(73.0)		97(43.1)	128(56.9)	
Devadasi status			0.410			0.611
Non-Devadasi	196(48.4)	209(51.6)		446(54.8)	368(45.2)	
Devadasi	532(46.0)	624(54.0)		275(56.2)	214(43.8)	
No of living children (own/biological)			<0.001			<0.001
None	126(29.6)	299(70.4)		108(46.0)	127(54.0)	
1	166(40.8)	241(59.2)		169(54.2)	143(45.8)	
2	240(55.3)	194(44.7)		221(54.6)	184(45.4)	
3+	196(66.4)	99(33.6)		224(63.3)	130(36.7)	
Monthly income from sex work			<0.001			<0.001
<3000	647(70.6)	269(29.4)		391(63.4)	226(36.6)	
3000+	81(12.6)	563(87.4)		331(48.0)	358(52.0)	
Source of income other than sex work			<0.001			0.035
No	204(23.6)	662(76.4)		276(51.8)	257(48.2)	
Yes	522(75.5)	169(24.5)		446(57.7)	327(42.3)	
Main place of solicitation			<0.001			<0.001
Home	585(80.5)	142(19.5)		283(82.5)	60(17.5)	
Brothel/Lodge	3(0.7)	450(99.3)		69(31.1)	153(68.9)	
Street	123(37.0)	209(63.0)		241(45.3)	291(54.7)	
Others	17(34.7)	32(65.3)		128(62.1)	78(37.9)	

clients per day			<0.001	<0.001
1	415(88.5)	54(11.5)	12(75.0)	4(25.0)
2	246(74.1)	86(25.9)	280(70.5)	117(29.5)
3+	67(8.8)	693(91.2)	429(48.2)	461(51.8)

Source: from the field survey of this study.
[§]P-value is for χ^2 test of independence comparing the place of residence.

Findings from the bivariate analysis suggest that the individual, cultural, and environmental variables related to out-migration were almost similar among the rural and urban FSWs, except the few variables like district and current age. The extent of migration among the rural and urban FSWs was higher among those who speak more than three languages, who does not have any children, those with average monthly income of Rs 3000 and above, brothel-based FSWs, and who have more than three clients per day. Findings also suggested that a higher proportion of migration FSWs were those who did not have any other source of income than sex work. The association between migration and having source of income other than the sex work was stronger in the rural areas.

Findings also suggest an association of place of enumeration (district) and age of the FSWs with their migration status. However, the results were different for the rural and urban FSWs. Results indicate a high volume of migration among rural FSWs from Bagalkot district as compared to those belonged to Belagavi and Vijayapura districts. In contrast, a higher proportion of urban FSWs from Belagavi reported about the migration in the last one year preceding the survey. Although, in both rural and urban areas, FSWs aged less than 25 years reported a high level of migration; rural FSWs in the age group 30-34 years and urban FSWs in the age group 25-29 had a high level of migration in the last one year preceding the survey. Importantly, literacy status and being *Devadasi* were not significantly associated with the migration status of both rural and urban FSWs.

Table 15: Results of multivariate logistic regression analysis showing association between individual, structural, environmental and cultural factors with FSWs migration status

Characteristics	Rural		Urban	
	Adjusted OR (95% CI) *	P [§]	Adjusted OR (95% CI) *	P [§]
Number of languages speak				
1	1.00(Ref)		1.00(Ref)	
2	1.39(0.96-2.01)	0.084	1.22(0.93-1.59)	0.148
3+	2.26(1.47-3.46)	<0.001	1.55(1.12-2.14)	0.008
Literacy status				
Illiterate	1.00(Ref)		1.00(Ref)	
Literate	1.45(0.99-2.11)	0.056	0.7(0.54-0.91)	0.007
No of living children				
None	1.00(Ref)		1.00(Ref)	
1	0.91(0.57-1.44)	0.681	0.67(0.47-0.96)	0.031
2	0.65(0.42-1.03)	0.064	0.78(0.55-1.11)	0.171
3+	0.51(0.31-0.85)	0.010	0.56(0.38-0.83)	0.003
Monthly income from sex work				
<3000	1.00(Ref)		1.00(Ref)	
3000+	7.24(4.88-10.76)	<0.001	1.91(1.45-2.51)	<0.001
Source of income other than sex work				
No	1.00(Ref)		1.00(Ref)	
Yes	0.31(0.22-0.45)	<0.001	1.03(0.77-1.36)	0.864
No. clients per day				
†	2.9(2.48-3.40)	<0.001	1.25(1.15-1.36)	<0.001

*Odds ratios adjusted for all variables shown in the table along with age, district and marital status.

Ref indicates reference or baseline; AOR, adjusted odds ratio; CI, confidence interval

† Adjusted odds ratio represents the increase in odds with each additional client.

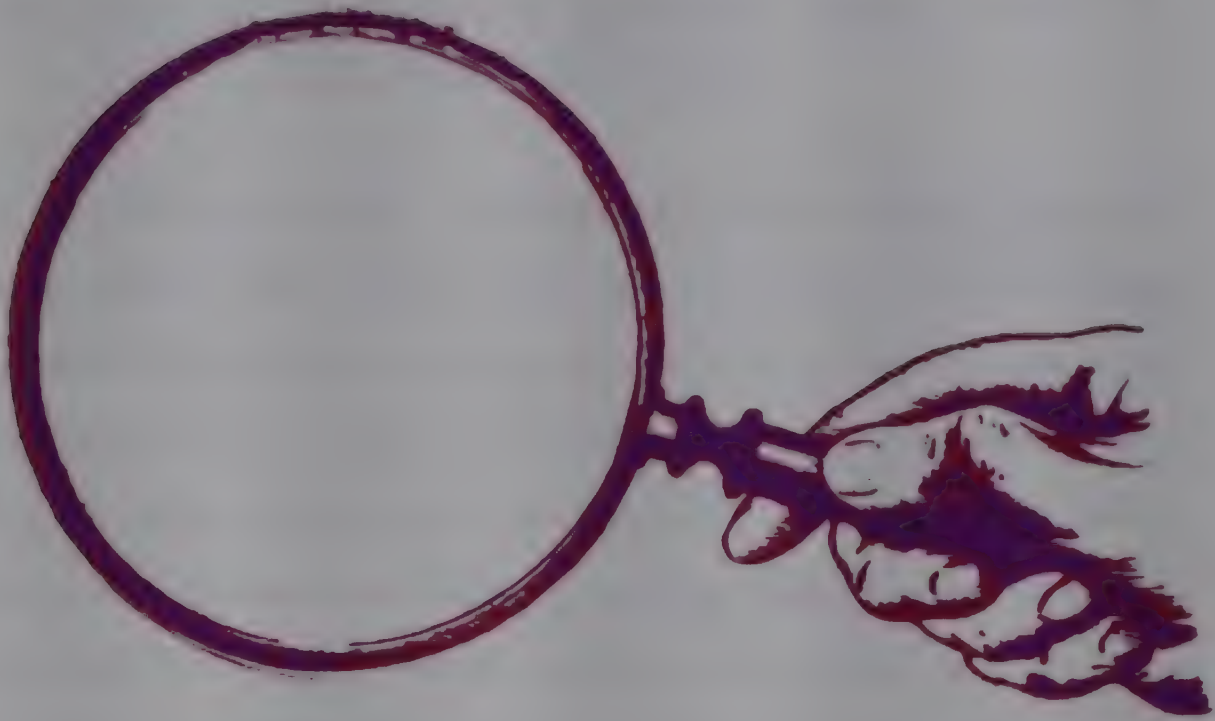
§P-value is for χ^2 test of independence comparing the place of residence.

Source: from the field survey of this study.

Findings from the multivariate analysis were almost in similar line as observed in the bivariate analysis except the fact that after adjusting for the effect of selected individual, cultural, and environmental characteristics, literate FSWs from the rural areas were more likely to migrate (AOR: 1.45; 95% CI: 0.99-2.11) while those from the urban areas had lower chances of migration (AOR: 0.7; 95% CI: 0.54-0.91) compared to their respective counterparts who were non-literate. Unlike the findings of bivariate analysis, results from

multivariate analysis suggests that after adjusting the effects of other confounders, FSWs who can speak more than two languages were more likely to migrate (AOR: 1.39; 95% CI: 0.96-2.01 for rural FSWs; AOR: 1.22; 95% CI: 0.93-1.59 for urban FSWs) than their counterparts who just speak only one language. Similarly, rural and urban FSWs having more than three children had lower likelihood (AOR: 0.51; 95% CI: 0.31-0.85 for rural FSWs and AOR: 0.56; 95% CI: 0.38-0.83 for urban FSWs) and those who had monthly income of Rs 3000 or more had higher likelihood (AOR: 7.24; 95% CI: 4.88-10.76 for rural FSWs and AOR: 1.91; 95% CI: 1.45-2.51 for urban FSWs) of migration in the one year period preceding the survey. A unit increase in having more number of clients per day was also associated with the higher likelihood of migration among both rural and urban FSWs (AOR: 2.9; 95% CI: 2.48-3.40 for rural FSWs; AOR: 1.25; 95% CI: 1.15-1.36 for urban FSWs). Lastly, rural FSWs having other source of income than the sex work were less likely to move out of the village where they were currently staying (AOR: 0.31; 95% CI: 0.22-0.45). Such relationship did not hold good for the urban FSWs (AOR: 1.03; 95% CI: 0.77-1.36).

CHAPTER-6



SEXUAL BEHAVIOUR AND HIV RISK AND VULNERABILITIES

CHAPTER 6

SEXUAL BEHAVIOUR AND HIV RISK AND VULNERABILITIES

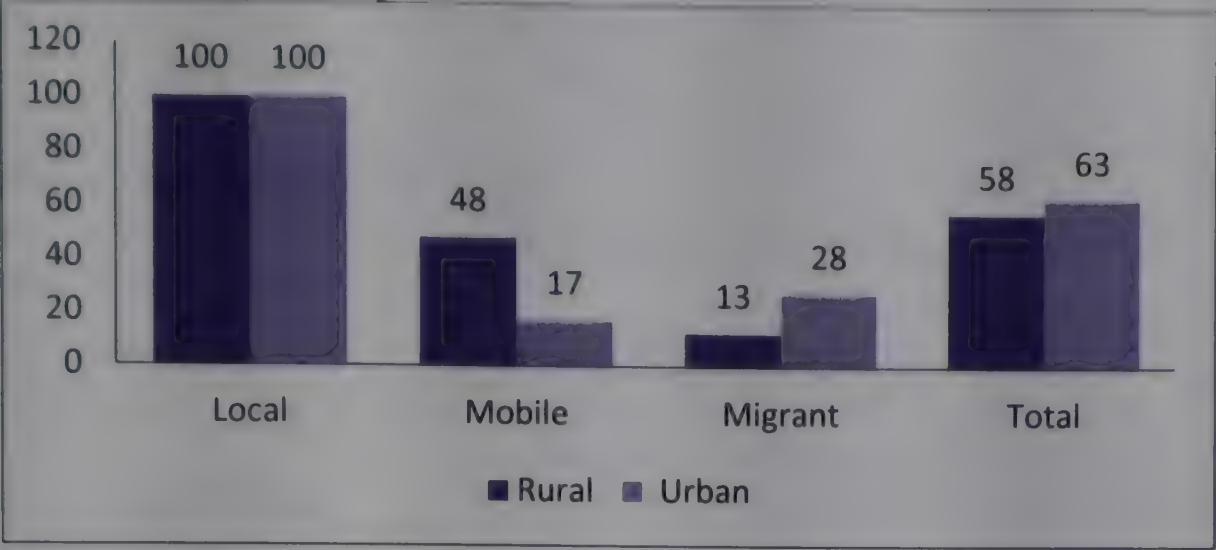
This chapter presents the findings for fourth and last objective and aims to analyze and describe the sexual behavior and associated HIV risk and vulnerabilities among FSWs in place of residence and the different destinations they visits for sex work. Quantitative and qualitative findings related to the place of solicitation, place of entertaining clients, source of clients, clients volume, type of sexual partner, number of sex acts and the condom use pattern with different partners were presented. Also, the association between FSWs sexual behavior and related HIV risk and vulnerabilities were discussed comprehensively.

6.1 FSWs sexual behaviour and HIV risk and vulnerabilities in place of residence

Among 2867 total respondents, 1725 (60%) are currently engaged in sex work in their place of origin (figure 18). All the local FSWs from both rural and urban areas are currently practicing sex work in their local place. Whereas, 48% of rural mobile and 17% of urban mobile FSWs and 13% of rural migrant and 27% of urban migrant FSWs engaged in sex work in their place of origin.

Both rural and urban migrants FSWs have shared the reasons for not practicing sex work in their natives. Many rural migrants said they spend most of their time in destinations, and they visit native village occasionally for festivals, fairs *jatras*, and any emergencies. So that, they won't prefers to practice sex work in these short visits to their natives.

Figure 18: Percentage of FSWs by sex work practice according to migration/mobility status



I stay 11 out of 12 months a year in Bhawandi and remaining one month in my village. Only my mother is there in the village, and even my children go to school here in Bhawandi...all my life is here in Bhawandi, and so I don't practice sex work in the village (Rural FSW, Age 26, Bagalkot).

I go to Yellamma's jatre on muthide hunnime [full moon day]. I also go in between if there is an emergency like death, wedding, etc. If there is nothing special, then I go once a year to my village. So I don't prefer to practice sex work in my native during these days (Rural FSW, Age 22, Vijayapura)

Similarly, urban mobile FSWs said, they frequently visit different places for sex work and would prefer to rest while in the hometown. Also, maintaining anonymity in sex work is other reason for urban mobile FSWs for not practicing sex work in their hometown.

I practice sex work without the knowledge of my family and neighbors. People in my locality will dishonor if they know me practicing sex work... it also affects my children life. So whenever to get a chance, I go other place and practice sex work there (Urban FSW, Age 35, Belagavi)

Table 16: Percent distribution of FSWs by their sexual behavior in place of origin according to place of residence

	Rural N=900 (%)	Urban N= 825 (%)	Total N=1725 (%)	P [§]
Does sex work in the village of origin?				<0.001
Yes	900 (57.7)	825 (63.2)	1725 (60.2)	
Main place of solicitation				<0.001
Own house	577 (64.5)	211 (25.6)	788 (45.8)	
Brothel	2 (0.2)	57 (6.9)	59 (3.4)	
Street	27 (3.0)	250 (30.2)	277 (16.1)	
Someone else's house	134 (15)	91 (11.0)	225 (13.1)	
Through phone	11 (1.2)	82 (9.9)	93 (5.4)	
Agriculture field	124 (13.9)	0 (0.0)	124 (7.2)	
Other	20 (2.2)	134 (16.3)	144 (9.0)	
Main place of having sex				<0.001
Own house	579 (64.7)	286 (34.7)	865 (50.3)	
Rented room	3 (0.3)	77 (9.3)	80 (4.7)	
Lodge	3 (0.3)	104 (12.6)	107 (6.2)	
Brothel	1 (0.1)	67 (8.1)	68 (4.0)	
Someone else's house	155 (17.3)	187 (22.7)	342 (19.9)	
Agricultural field	148 (16.5)	0 (0.0)	148 (8.6)	
Others	6 (0.7)	104 (12.6)	110 (6.4)	
Source of clients				<0.001
Clients come on their own	600 (67.0)	380 (46.1)	980 (57.0)	
Independently	220 (24.7)	347 (42.1)	567 (33.0)	
Through friends	63 (7.0)	55 (6.7)	118 (6.9)	
Through others (clients, brokers, madams)	12 (1.3)	40 (4.8)	52 (3.0)	
No of clients per day				<0.001
1	492(54.7)	18(2.2)	510(29.6)	
2	306(34)	335(40.6)	641(37.2)	
3+	102(11.3)	472(57.2)	574(33.3)	
Mean no of clients per day	1.6	3.1	2.0	
No of sexual acts per day				<0.001
1	444(49.3)	2(0.2)	446(25.9)	
2	311(34.6)	234(28.4)	545(31.6)	
3+	145(16.1)	589(71.4)	734(42.6)	
Mean no of sex acts per Day	1.8	3.8	2.2	
Types of sexual partners*				
Occasional clients	639 (71.4)	665 (80.6)	1304 (75.8)	
Regular clients	792 (88.5)	734 (89.0)	1526 (88.7)	
Intimate partners	560 (62.6)	442 (53.6)	1002 (58.3)	

Consistent condom use with occasional clients				0.033
No	94 (14.5)	4 (0.6)	97 (7.4)	
Yes	549 (85.5)	662 (99.4)	1211 (92.6)	
Consistent condom use with regular clients.				0.011
No	198 (24.8)	83 (11.3)	281 (18.3)	
Yes	594 (74.4)	649 (88.7)	1243 (81.2)	
Consistent condom use with intimate partner				0.001
No	536 (78.4)	473 (79.1)	1009 (78.9)	
Yes	146 (21.3)	125 (20.9)	271 (21.1)	
Main reason for not using condoms with intimate partner				<0.001
I trust them	314(58.6)	265(56.0)	579(57.4)	
They refuse	114(21.3)	142(30.0)	256(25.4)	
Want to get pregnant	61(11.4)	16(3.4)	77(7.6)	
Don't like it	18(3.4)	14(3.0)	32(3.2)	
Other	29(5.4)	36(7.6)	65(6.4)	

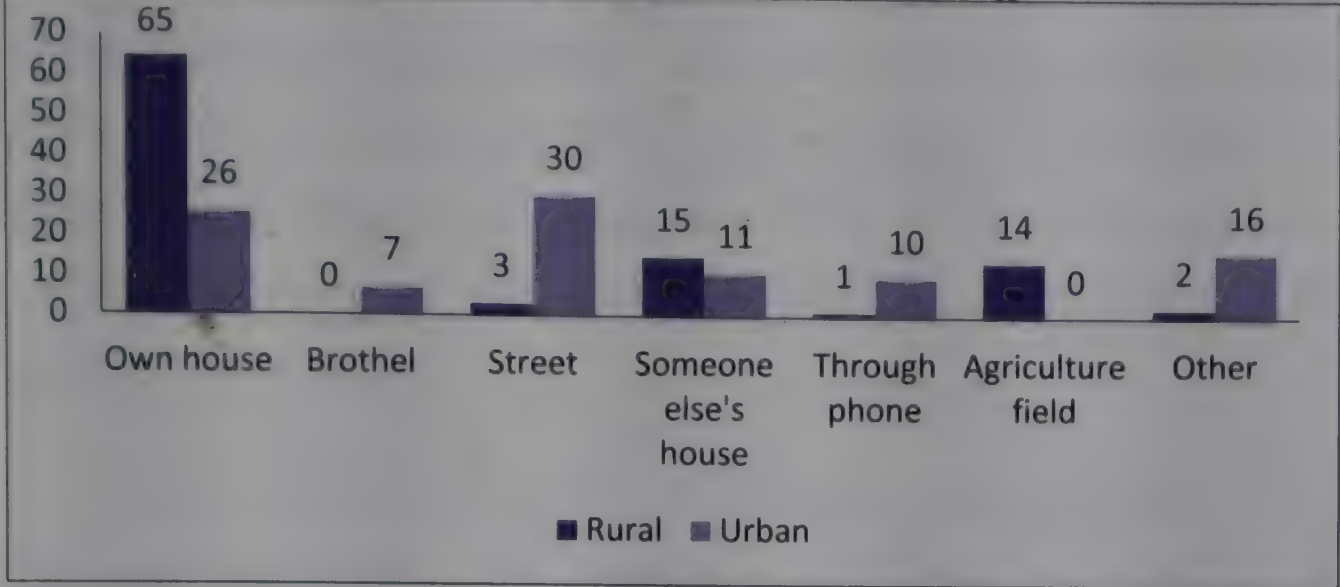
* Multiple choice questions

Source: from the field survey of this study.

[§]P-value is for χ^2 test of independence comparing the place of residence.

In the place of origin, more than half of the (64%) rural FSWs solicit and entertain their clients in their homes and half a quarter of rural FSWs solicit and entertain clients in an agricultural land. Urban women solicit clients in a variety of places including street (30%), their house (26%), and someone else's house (11%) and through phone (9.9%). And also, urban FSWs entertain their clients in their house (35%), someone else's house (23%), lodge (13%), and rented rooms (9%). It indicates that urban FSWs who practice sex work in their place of origin fall under different typology of sex work and they prefer to entertain clients in different places. This is very uncommon among rural FSWs practicing sex work in their village.

Figure 19: Percent distribution of FSWs by main place of solicitation of clients according to the place of origin



To understand more about the sex work industry in place of residence, the FSWs asked whether they solicit clients independently or with the help of mediators. Most (67%) rural women mentioned about their clients coming on their own in their village, 24% claim they solicit clients independently, 7% with the help of friends and only 1% with the assistance of clients, brokers or madam. This is slightly different among urban FSWs practicing sex work in their place of origin, and almost equal proportion mentioned about clients come on their own (46%) and solicit clients independently (42%). Few urban women also get clients through friends (7%) and others which include clients, brokers, and madams (5%). Therefore, both rural and urban sex work in the three study districts practiced mostly on an individual basis and the network operator’s contribution is very limited.

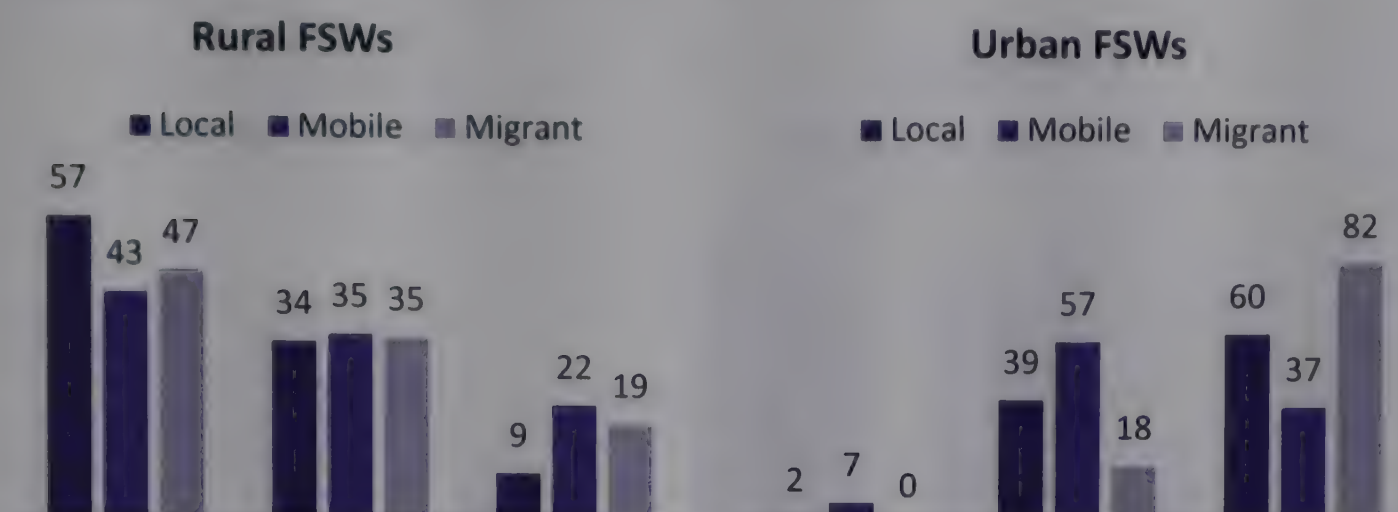
Being a traditional *Devadasi* sex worker is an important reason for rural FSWs to predominantly practice sex work in their respective home. Qualitative findings have enlightened about the sex work environments of rural FSWs and in most of the cases, families of rural FSWs are well aware of women practicing sex work in their home. Also, they encourage and support the women practicing sex work in the home environment since this is a primary source income for the family. Women practicing sex work in the home have separate room

within the house where they entertain clients. The rooms they practice sex work consists of a cot, bed, water and a washroom facilities. Generally, other family members don't enter into these rooms and the clients visiting home-based FSWs have an access to direct entry into these rooms. Women practicing sex work in the home are more secured and have an easy access to clients as compared to other typology of sex work.

Rural women have also mentioned about practicing sex work in the agriculture field. One woman said, *"I do sex work in the agriculture field...when I am going to work in an agriculture field...I talk to the workers who work in the field and make a deal there itself...It happens if the owner of the field is not there. I do entertain them in the field itself"* (Rural FSW, age 32, Bagalkot). Whereas urban FSWs prefer to have their clients from multiple sources, and that would be another reason for urban FSWs to have more number of clients as compared to rural FSWs.

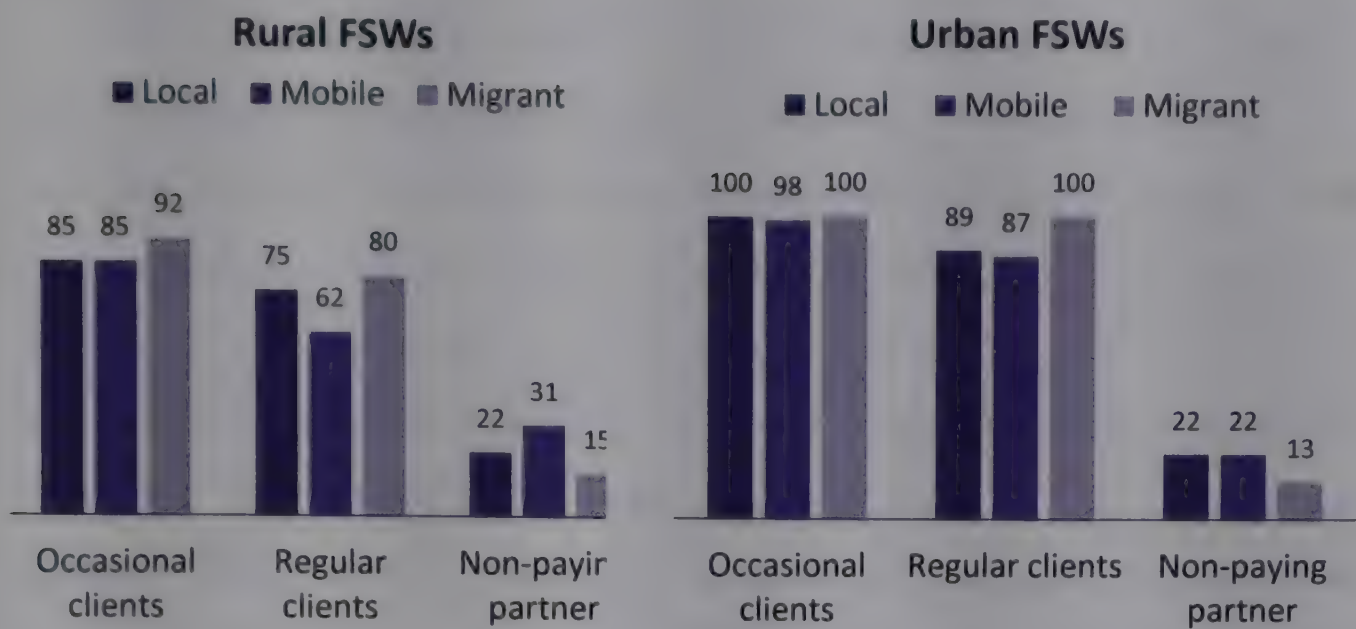
Most rural FSWs have 1 to 2 clients per day (mean 1.6). But urban FSWs have higher client load (mean 3.8) compared to rural FSWs. To examine the level of risk involved in sex work, client volume in place of residence was examined along with their mobility status for both rural and urban FSWs. Among rural FSWs, rural mobile women entertain more clients a day as compared to rural local and migrant FSWs. In contrast, urban migrant women entertain more clients in a day as compared to urban local and mobile women (see Figure 20 below). This is similar to a number of sex acts FSWs having a day and as compared to rural (mean 1.8), urban (mean 3.8) FSWs have more numbers of sexual acts in a day. Virtually all rural and urban FSWs have only vaginal penetrative sex with their clients, and anal sex is reported as being uncommon.

Figure 20: Percentage of FSWs by daily client volume and migration/mobility status according to place of residence



In place of residence, most of the rural and urban FSWs have both occasional (rural 71%, urban 81%) and regular clients (rural 88%, urban 89%). Compared to rural FSWs, urban FSWs tend to have more occasional and regular clients and less intimate partners. On the other hand, both rural and urban FSWs have consistent condom use with occasional clients (rural 85%, urban 99%) and regular clients (rural 74% and urban 89%). But the regular condom use with an intimate partner is very low among both rural (21%) and urban (21%) FSWs. To examine the risky sexual behavior more specifically, condom use with different partners in place of residence was examined with their mobility status for both rural and urban FSWs. Condom use is very high among rural migrant women with occasional clients (92%) and regular clients (80%) in place of residence, as compared to rural local and mobile FSWs. Rural migrants reported less condom use with their intimate partners as compared to rural local and mobile FSWs. But among urban FSWs condom use is very high despite their mobility status. It is possible that there is a social desirability bias to over report condom use among rural migrant and urban FSWs. Still, the low reported condom use with intimate partners is noteworthy.

Figure 21: Percentage of FSWs by condom use with different partner and migration/mobility status according to place of residence



Both rural and urban FSWs were asked regarding reasons for using and for not using condoms consistently. Most of the rural and urban FSWs mentioned the fear of HIV/AIDS as the most important reason for using condom in the case of occasional and regular clients. The rural and urban FSWs who do not use condom consistently with their intimate partner said, it is because they trust their partner (rural 59%, urban 56%), the partner refuses to use condom (rural 21%, urban 30%) or the women want to get pregnant (rural 11%, urban 3%). Findings suggest that the intimate relationships of both rural and urban FSWs were based upon trust, emotional attachment and most of them have defined their relationship as ‘like marriage’ which was the most important reason to reduce their motivation to use a condom. One of the respondents reply reflect the attitude of the women; she said,

“We would have given our hearts to those who are khaayam [intimate/permanent], so the sexual contact will be good. But with the unknown people and with those whom we do not like, it will be sittakka-pattakka [irritating, and annoying] with the khyaam person

our hearts would have mingled. So sex is good with them” (rural FSW, age 29, Bagalkot).

Most of the FSWs said, insisting condom use in an intimate relationship could strongly affect the longevity, trust, and intimacy in the relationship. One of the women interviewed said; *it’s hard to insist on a condom with our hiriya [intimate partner] because they will question...why you want to use condoms even if I am your lover. For clients, I can tell them “Khulla’ [openly]...only take them, if they use condoms. But for hiriya...it’s hard to ask them to use a condom” (urban FSWs, age 27, Belagavi).* Interestingly, most of the intimate partners of both rural and urban FSWs are married, and they play an integral role as bridge populations, facilitating the transmission of HIV and STI to female partner outside the context of sex work.

Many differences found among rural and urban FSWs in their sex work setting including the place of solicitations, place of having sex and the source of clients. Also, urban FSWs are at an increased risk of getting HIV considering their high client volume. But virtually, consistent condom use with occasional and regular client among urban FSWs is comparatively high. Similarly, rural FSWs have low client volume, but their consistent condom use with the occasional and regular client is comparatively low. Most importantly, condom use with the intimate partner is significantly low among both rural and urban FSWs, and this significantly increases their risk of getting HIV/AIDS.

6.2 FSWs sexual behavior and HIV risk and vulnerabilities in most recent place of visit

To assess whether the experience of mobility/migration poses a higher risk of HIV for women who practice sex work in other places, respondents were asked the same questions as in the previous section regarding their sexual behavior at the most recent place of destination (Table 17). The distinction between the experiences of rural/urban mobile and migrant women has been made.

Table 17: Percent distribution of FSWs by their sexual behavior in place of most recent destination according to place of residence

	Rural Migrant N=833 (%)	Urban Migrant N=582 (%)	Total N=1415 (%)	P [§]
Main place of solicitation				<0.001
Brothel	416 (50)	93 (16.0)	509 (36.0)	
Street	199 (24.2)	285 (49.0)	487 (34.4)	
Someone else's house	44 (5.3)	15 (2.6)	59 (4.2)	
Rented room	65 (7.8)	38 (6.5)	103 (7.3)	
Lodge	29 (3.5)	55 (9.5)	84 (5.9)	
Through Phone	17 (2.0)	63 (10.8)	80 (5.7)	
Other	59 (7.1)	33 (5.7)	92 (6.5)	
Main place of sex				<0.001
Rented room	81 (9.7)	99 (17.0)	180 (12.7)	
Lodge	95 (11.4)	241 (41.4)	336 (23.8)	
Brothel	546 (65.6)	124 (21.3)	670 (47.4)	
Someone else's house	55 (6.6)	92 (15.8)	147 (10.4)	
Others	55 (6.6)	24 (4.5)	81 (5.8)	
Source of clients				<0.001
Clients come on their own	431 (51.8)	233 (40.0)	664 (47.0)	
Independently	350 (42.1)	310 (53.3)	660 (46.7)	
Through others (clients, husbands, brokers, madams friends)	51 (6.1)	28 (4.8)	79 (5.6)	
No of clients per day				<0.001
1	54(6.5)	4(0.7)	58(4.1)	
2	86(10.3)	117(20.1)	203(14.3)	
3+	693(83.2)	461(79.2)	1154(81.6)	
Mean no of clients per day	4.9	3.8	4.6	

No of sex acts per day				<0.001
1	37(4.4)	0(0.0)	37(2.6)	
2	72(8.6)	67(11.5)	139(9.8)	
3+	724(86.9)	515(88.5)	1239(87.6)	
Mean no of sex acts per day	5.5	4.4	5.1	
Types of sexual partners*				
Occasional clients	788 (94.4)	532 (91.4)	1320 (93.4)	
Regular clients	719 (86.5)	521 (89.5)	1240 (87.8)	
Non-paying partner	144 (17.3)	88 (15.1)	232 (16.4)	
Consistent condom use with occasional clients				0.033
No	19 (2.4)	2 (0.4)	21 (1.6)	
Yes	770 (97.6)	530 (99.6)	1300 (98.4)	
Consistent condom use with regular clients.				0.011
No	66 (9.2)	32 (6.1)	98 (7.9)	
Yes	653 (90.8)	490 (93.9)	1143 (92.1)	
Consistent condom use with intimate partner				<0.001
No	108 (71.1)	63 (67.7)	171 (69.8)	
Yes	44 (28.9)	30 (32.3)	74 (30.2)	
Main reason for not using condoms with intimate partner				<0.001
I trust them	68(63.0)	39(61.9)	107(62.6)	
They refuse	19(17.6)	17(27.0)	36(21.1)	
Want to get pregnant	19(17.6)	5(7.9)	24(14.0)	
Other	2(1.9)	2(3.2)	4(2.3)	

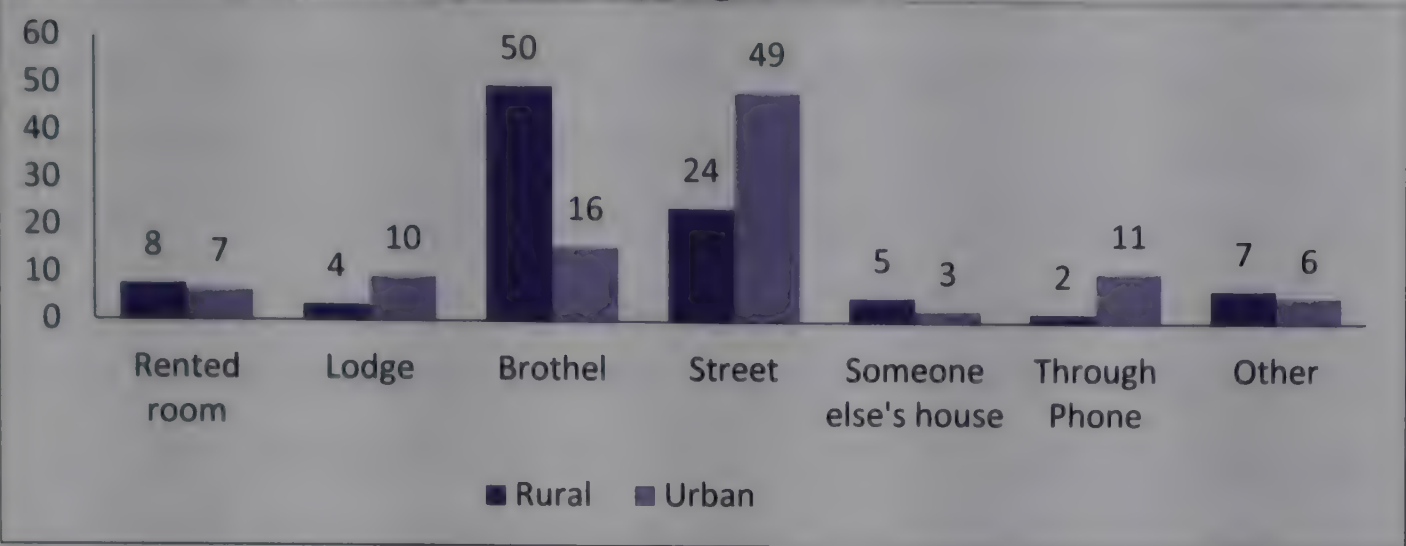
* Multiple choice questions

Source: from the field survey of this study.

[§]P-value is for χ^2 test of independence comparing the place of residence.

Rural FSWs work in a completely different sex work setting when they move different places for sex work. Around 50% of the rural FSWs get their clients in the brothel and another 24% in the street. Also, 65% of rural FSWs entertain their clients in brothels. Sex work set-up at the place of destination is significantly different for urban FSW, and they solicit clients in a variety of places: street (49%), brothels (16%), and Lodge (10%). Also, around 11% of urban FSWs solicit their clients through phone, and this is more of a recent development in the typology of sex work. Urban FSWs have sex with the clients mainly in the lodge (41%), brothel (21%), rented rooms (17%) and someone else's house (16%).

Figure 22: Percent distribution of FSWs by main place of solicitation of clients according to place of residence

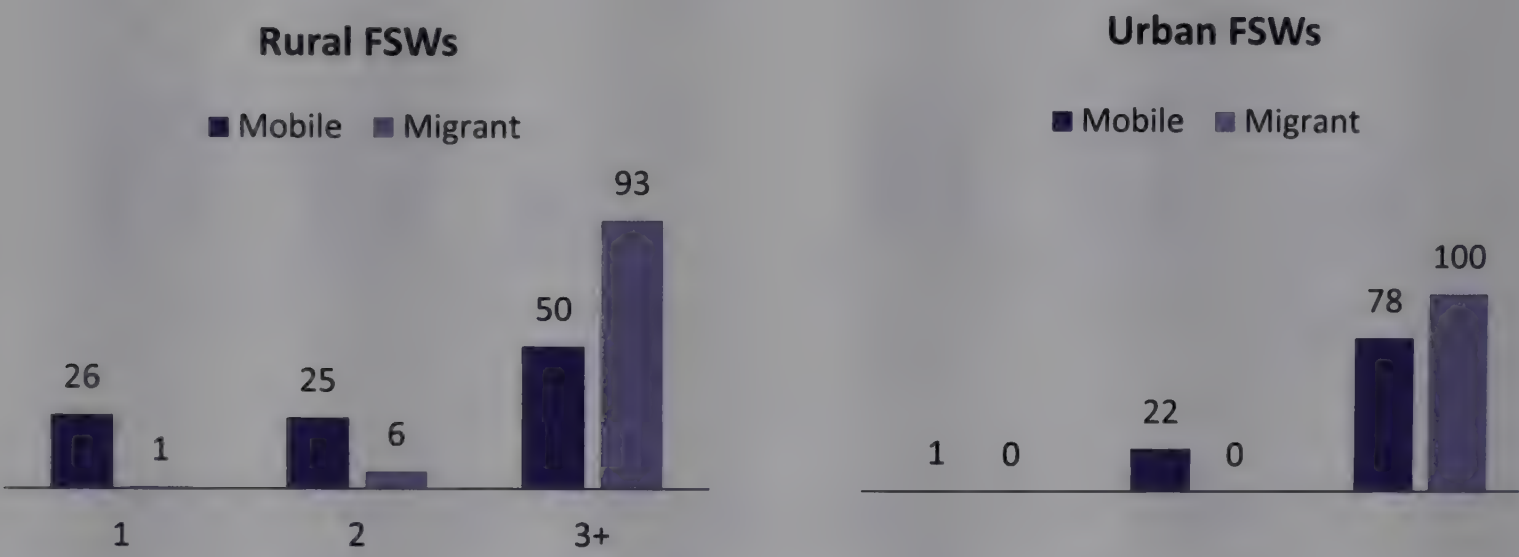


At the place of destination, a large majority of rural and urban FSWs report that they solicit clients independently (rural 52%, urban 40%) or that the clients come on their own (rural 52%, urban 53%). A small proportion of FSWs also get their clients through husband/lovers, brokers, madams, friends and clients (rural 6%, urban 5%) and therefore, as compared to their place of residence, sex work in the place of destination has more contribution of network operators.

Compared to their place of residence, both rural and urban FSWs have a significantly higher client volume at the place of destination (Figure 22). On an average, rural women have 4 to 5 clients per day (mean 4.9), and urban women have 3 to 4 clients per day (mean 3.8). Client volume is also assessed based on the mobility status and both rural, and urban migrants have more client volume in place of destinations as compared to mobile FSWs. The number of sex acts per day in the most recent destination is also high and rural women have 5 to 6 sex acts in a day (mean 5.5), and urban women have 4 to 5 sex acts in a day (mean 4.4). Similar to their experience in the village, the large majority of women report having only vaginal penetrative sex with their clients in the most recent destination as it is the normal and accepted form of sex.

The study also reveals that women felt the changes in sex work setting, client volume and the number of women visiting these places for sex work over the past ten years. Many senior FSWs said, earlier the brothels were located in one particular place in each destination, but now it has scattered in different places of the city. So that the men visiting sex workers seems to be low, and the women in older brothels have also seemed to be less. One migrant FSW said, *compare to the past; now the dhandha has decreased. People are scared of diseases, and fewer men visit women in these days (Rural FSW, age 30, Bagalkot).*

Figure 23: Percentage of FSWs by daily client volume and migration/mobility status according to place of residence

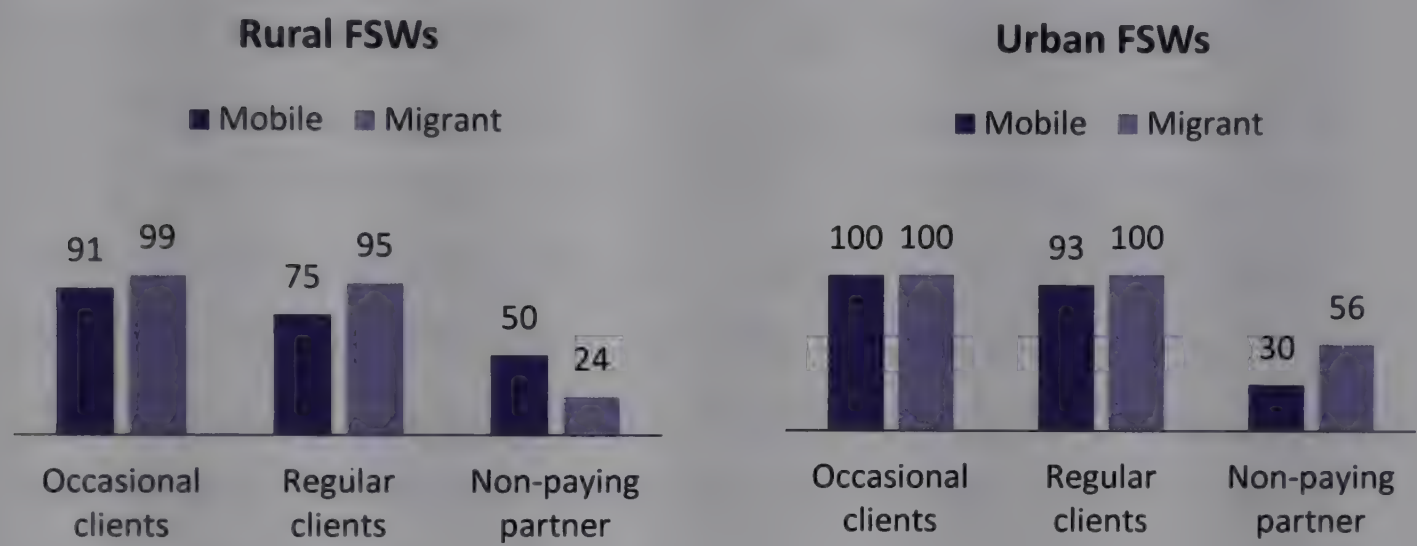


Almost all the rural and urban women have occasional (rural 94%, urban 91%) and regular clients (rural 86%, urban 89%) in place of most recent destination. But only 17% of rural and 15% of urban FSWs have non-paying partners in these places. This may be because most of the rural FSWs work in brothels and urban FSWs visit destination for a shorter duration, which makes it relatively difficult for both rural and urban FSWs to have regular partners in place of destination. Qualitative exploration revealed that generally brothel madams don't allow women to have an intimate partner since brothel madams have invested on these women, and brothel madams think,

women having an intimate partner will effect on her business. One respondent said;

I don't have any partner here in this place. Because, if my garwali come to know about me having a partner...she may kick me out...even she won't allow the girls to get pregnant...because it effects her business'' (Rural FSW, age 28, Vijayapura)

Figure 24: Percentage of FSWs by condom use and migration/ mobility status according to place of residence



Both rural and urban FSWs report high consistent condom use with the occasional client (rural 98%, urban 99%) and slightly lower proportion of consistent condom use with regular clients (rural 91%, urban 94%). But very low condom use is reported with their intimate partners (rural 30%, urban 32%). Condom use in place of destinations was also examined along with their mobility status (figure above 24) and not much variation found. The large majority of rural and urban FSWs report that they use condoms consistently with their clients because they are afraid of HIV/AIDS. The women who do not use condoms consistently with their intimate partners says it is mainly because they trust their partner (rural 63%, urban 62%), the partners

refuse to use condoms (rural 18%, urban 27%), or they want to get pregnant (rural 18%, urban 8%).

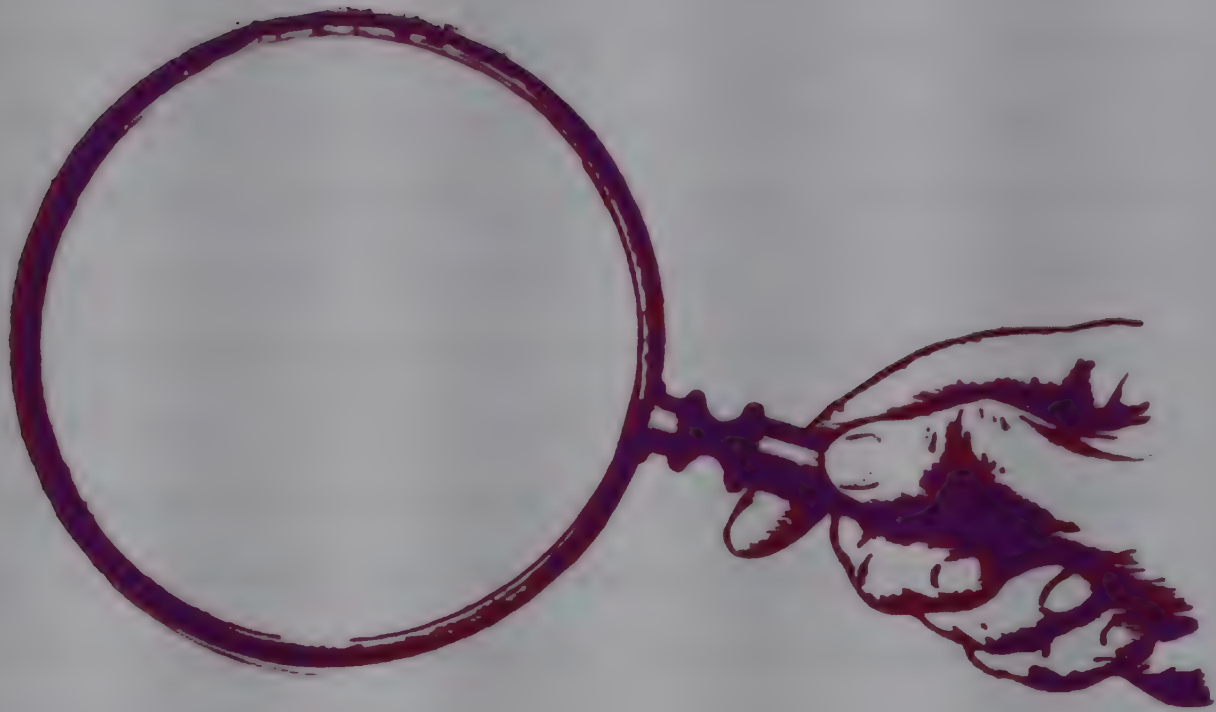
FSWs also face various difficulties in destinations to convince their client to use a condom. They say the clients who drink alcohol and who takes intoxicating drugs are always difficult to convince to use the condom. Some women also said men who refuse to use condom are always ready to pay more money and also, as compared to regular clients, new clients are bit tricky to convince about condom use. One respondent said, *"Some clients ask me to do sex without condoms. There are others who ask for those dirty things to be done which are the new trends that have come"* (rural FSWs, age 22, Bagalkot). Women have also differentiated the clients they get in source and destinations, and one women said, *"Village clients are birusu [rough and rude] but city clients are "midu"[soft]"* (Rural FSW, age 27, Bagalkot). They have also said, as compared to rural, urban clients are much younger and pay more. *In the village, they wear dhotara (a traditional form of dress men wear). But here, rare to find those rural clients and everyone wears pants and shirts. Also in the village, very few young boys come but here in Bhawandi, more young boys come.* (Rural FSW, age 20, Belagavi)

Many women mentioned about their lack of knowledge about the condom when they first started sex work and said, it took three months to one year to learn how to use a condom and its importance. One woman said *I started using this without hesitation a year after I started doing dhandra. No one taught when I entered this profession...later Garwali and the friends in brothel taught me about the condom.* (Rural FSW, age 30, Vijayapura).

A significant difference found among rural and urban FSWs when they move other places for sex work. The mobility/migration

puts both rural and urban FSWs at a higher risk for HIV, as they have more clients and number of sex acts significantly at the place of destination compared to their place of origin. Virtually, consistent condom use among both rural and urban FSWs is very high with all three types of partners in the most recent destination as compared to their place of origin. It should also be noted that the large majority of study sample included FSWs with several years of experience.

CHAPTER-7



SUMMARY
CONCLUSION AND
WAY FORWARD

CHAPTER 7

SUMMARY CONCLUSION AND WAY FORWARD

The overall goal of this study is to increase the knowledge about migration and mobility pattern, and associated HIV risk and vulnerabilities among rural and urban FSWs in northern Karnataka district. To meet this goal, the study identified four objectives. 1. To understand the socio demographic, and sex work profile of rural and urban FSWs in northern Karnataka districts. 2. To compare the migration and mobility patterns of rural and urban FSWs in northern Karnataka districts. 3. To analyse the association between the individual, structural, environmental and cultural factors and the out-migration among FSWs. 4. To analyze and describe the sexual behavior and associated HIV risk and vulnerabilities among FSWs in northern Karnataka.

This chapter discusses the key findings from the study and related program, research, and, policy implications. The chapter has been presented in two sub-headings; first it begins with discussion on key study findings and later provides a conclusion and way forward. The study findings were compared and, discussed in line with other available literature and highlights how it relates to previously identified findings. Also, this chapter provides insight on the implications of findings on future HIV prevention programs involving migrant FSWs in Karnataka, and recommends a few additional studies. The chapter ends with a brief description of study strengths and limitations.

7.1 Summary of key study findings:

Rural FSWs in the three study districts of northern Karnataka are younger (mean age 27), and most of them are *Devadasis* (74%). In the native, they are mainly practicing sex work in the home based environment and have a support and acceptance from the family members. Illiteracy is predominant among rural FSWs and very few had an opportunity to attend schools. The study shows that around 81% of rural FSWs are not able to read and write, and almost 78% of them have not attended the school. The explanation for the lower levels of literacy reported by rural FSWs may also lie in the circumstances of entry into sex work.

As compared to rural FSWs, urban FSWs are older, and the mean age of urban FSWs was 31. Urban FSWs are much better in terms of literacy (32% can read and write, and 35% have attended school), but still it is very low as compared to overall literacy rate in this region which is 67%, 68% and 73% for Vijayapura, Bagalkot and Belgaum districts respectively (International Institute for Population Sciences, 2012-13; Office of the Registrar General and Census Commissioner, 2011). Another key difference between rural and urban FSWs is in their marital status. Around 74% of rural FSWs are *Devadasis*, and as it is the tradition, they never married a mortal man. Whereas most of the urban FSWs were either currently married, separated, divorced or widowed. Among the urban FSWs, more than 84% got married before the age of 18. This indicates the prevalence of child marriage, and this would be a plausible reason for many urban FSWs to enter sex work after becoming separated from family life due to husband death, divorce or separation from married life. Despite being prohibited by law, child marriage is common in this region, particularly among those from low castes. Most recent data from DHLS IV indicates a higher percentage currently married women married below the age of 18 years in Belagavi (District total 27%, and

rural 35%), Bagalkot (District total 25%, and rural 33%) and Vijayapura (District total 24%, and rural 26%) districts (Beattie et al., 2015; Government of Karnataka, 2006; International Institute for Population Sciences, 2012-13). Previous studies have also shown the association between child marriage, entry into work and the greater risk of HIV in many setting (Clark, 2004). Similarly, the present study has also highlighted the association between early girl child marriage and the entry into sex work along with HIV risk among the women in this region. So these findings set red flags on many structural issues which cause HIV.

Most of the rural and urban FSWs are Hindus, and there are about 9% of urban FSWs belong to the Muslim religion. More than 60% of rural and urban FSWs are from families that include 4 to 8 family members, and a very few of them are living alone. More than 77% of both rural and urban FSWs have at least one or more biological children and 85% of them having a financial responsibility to take care of children. More interestingly, around 36% of rural FSWs don't have any children, and they would prefer not to have a child while they work at different destinations. Our multivariate analyzes have also shown that FSWs having more than three children had the lower likelihood of migration in the one year period preceding the survey. Not much difference found in the total income and expenditure pattern of rural and urban FSWs, except rural migrant FSWs earning more money from sex work. Earning from sex work is strongly associated with migration and in multivariate analysis; FSWs who have been earning a monthly income of Rs 3000 or more from sex work had reported the higher likelihood to migrate. Around 50% of rural and urban FSWs contribute their earning from sex work to the household income and more than 80% of them have an alternative family income from other family members including their lovers. In

the multivariate analysis, it was indicated that rural FSWs having other source of income than the sex work were less likely to move out of the village where they were currently staying.

The study has also highlighted the key differences in the sex work characteristics of rural and urban FSWs. One of the significant findings of this study is that around 63% of rural FSWs started sex work before they were 18 years of old, 41% of rural FSWs moved to another destination between 12 to 18 years of age and 41% of them have stayed in the sex work for more than ten years. Findings also show the role of family members in the early sexual debut of rural FSWs and many rural FSWs have been initiated into sex work through a ritual called “hennu maduvudu” or saragu hidisuvudu’ as part of *Devadasi* tradition. This is a ritual wherein the family negotiates a certain amount of money as well as gifts with a male from the same or different village. The male may even tie tali to the girl and may consider as the permanent or intimate partner. This male has the right to consummate the relationship with her. The family may negotiate this process on its own or through another elderly *Devadasi* or a mutual acquaintance. Generally, the young girl doesn't have any say in this negotiation or the person who has sex with her for the first time (Ramanaik et al., 2014; Shankar, 1990).

The study findings show that rural FSWs enter sex work at very young age, move early to the different destination for sex work and stay in the profession for a longer period. Early sexual debut and practicing sex work in a high-risk environment for an extended period has a major implication on HIV transmission dynamics of rural FSWs. HIV prevalence assessments among FSWs (known as Integrated Biological and Behavioral Assessments (IBBA)) have shown that HIV prevalence rises very quickly by age and duration in sex work, and plateaus after that (KHPT, 2013). This suggests that most of the rural

FSWs go through a very high-risk period when they first start sex work and staying in the sex work for a longer period will enhance their vulnerabilities to HIV. Also, initially, they start sex work in a more hidden environment and move different destinations for sex work. This made them not accessible to health services and HIV prevention programs in this region are formally reaching them at the later stage. Studies conducted on FSWs entry into sex work in this region have also shown the similar results and delayed access to health services have made rural FSWs more vulnerable to HIV (McClarty et al., 2014; Mishra et al., 2012). In the quantitative survey, family's financial need and *Devadasi* tradition echoed as prime reasons for women entering into sex work. But an in-depth analysis qualitative study has highlighted the different underlying cause for women entering sex trade, and it includes lack of education, lower socioeconomic status, domestic violence, child marriage, dowry, family debt, husband's alcoholic addiction, etc. Applying qualitative methods in this study, within the explanatory sequential design has significantly contributed to better understand these structural drivers for women entering sex work in this region.

Another key important finding of this study is the migration and mobility pattern of rural and urban FSWs. The study results indicate that both rural and urban FSWs move to different places for the purpose of sex work. Migration and mobility pattern of rural and urban FSWs from the three study districts are very different. Rural FSWs tend to go to distant places and on each visit they stay an average period of 4 months. The most common destinations for rural FSWs are Pune, Sangli, Mumbai and Bhiwandi, all located in Southern and Central Maharashtra. To earn more money, chances of getting more number of clients, familiarity with the place and family related reasons are the main reasons women mentioned in the survey

to visit these places. But in the qualitative study, traditional *Devadasi* system and the historical connections with the brothels in red light areas was tinted as other plausible reason for the rural FSWs to move these towns and cities in Maharashtra. Similar to this, many studies have highlighted the involvement of rural women in sex trade business during different era including the most recent British colonial period. (Ashwini Tambe, 2009; Bhandari, 2010; Chang, 2007). Previous studies conducted in this region have also shown that many women from northern Karnataka have moved long back and had set up their own brothels in different towns and cities in Maharashtra (Blanchard et al., 2005; O'Neil et al., 2004). The brothel owners settled in these towns are continuing to recruit new women from their community and the village, which helped them to run their business smoothly. Still the rural women from the study districts are following the network established historically and migrating to different destinations in Maharashtra, following the women who have moved previously. It indicates that rural FSWs move through less informal networks and go to a particular place of destination based on the suggestions of other FSWs in the village or nearby area working in the same location.

On the other hand, urban FSWs tend to visit places within study district and spend very short time in their every visit. The main destinations for urban FSWs are the main towns in the district of origin or outside the district. Also, there is an important district wise variation for both rural and urban women, regarding their places of destination. Along with to make more money and clients, maintain anonymity was an important reason for the urban woman to visit nearby places. Urban FSWs from the study district start their migration at little later age, and most of their decisions related to migration are decided by herself or with the help of her friends or clients. Family member's role in urban FSWs migration is very less.

Whereas rural FSWs start migrating at very young age and decisions related to their first migration were decided by the family members. Family members of the rural FSWs play a critical role in the migration of women for sex work, including the selection of first destination, brothel and brothel madams and business deal with brothel madams. While virtually, most of the rural and urban FSWs decisions to visit different places are driven by economic reasons.

Initially, the study presumed that rural FSWs are more vulnerable and more at risk to HIV as compared to urban FSWs. However, the study found out that, rural FSWs involved in a very structured sex work in their place of origin and the different destinations they visit for sex work. Rural FSWs practice sex work in the home based setting in their native, where they have excellent family support. Home-based sex work setting and family support has given a secured environment for rural FSWs and best positioned them to deal with many social issues around sex work, including managing the difficult clients. Also, rural FSWs are less stigmatized to practice sex work as compared to urban FSWs, and this is because of their association with *Devadasi* tradition. Previous studies with *Devadasis* from this region has indicated the socio-cultural importance of *Devadasi* women and given ample instances for society regarded them as auspicious in many occasions including, marriage, jatra, and other religious concerts. In fact, they were not treated as sex worker/sule/prostitute per se (O'Neil et al., 2004; T. R. Orchard, 2007; T.R Orchard, 2007). Studies have also shown that *Devadasi* sex worker long-term and trusted relationship with an intimate partner has not just given them an economic security but have also given an opportunity to exchange emotional and physiological feelings (Ramanaik et al., 2014). Similarly, rural FSWs from the study districts are brought to brothels in Maharashtra through more or less informal

networks, and they practice sex work in a very structured sex work setting. They primarily solicit and entertain clients in brothels and practice sex work in the same place and very less likely to practice sex work in other places within the district. Previous studies have also shown that women practicing sex work in brothel have a favorable environment for soliciting clients and brothels also ensure client flow since the clients are aware of the constant availability of FSWs in brothels (Gurav K., 2013). Also, clients attending brothels may have more money to spend, and the brothel setup may make it easier to have many clients (Banandur et al., 2012).

In contrast, urban FSWs have a very high mobility pattern and short duration of stay in a particular place, and this makes them be a hard to reach population. Also, urban FSWs move to different places to preserve their anonymity and reported no preference for a place of solicitation and practiced sex work both within and outside the district. Previous studies have also highlighted that FSWs, who visit many places for shorter durations, may face higher socio-economic vulnerabilities such as experiencing violence, use of alcohol and have relatively little economic independence than less mobile FSWs (N. Saggurti, Jain, et al., 2012). Also, due to their high mobility status, urban FSWs may bridge local and nonlocal networks in HIV transmission (Banandur et al., 2012). Therefore, a higher degree of mobility with lesser durations of stay among urban FSWs would be measured as a considerably higher risk marker than rural FSWs.

The study also shows, a relatively small proportion of mobile (rural 48%, urban 17%) and migrant (rural 13%, urban 27%) FSWs from both rural and urban setting are currently engaged in sex work in their place of origin. This indicates that migrant and mobile FSWs play a relatively small role in HIV transmission in their village or town of origin in the near term. However, data suggests that a

relatively high proportion of local FSWs have a history of migration out of the district or state. This indicates that over the longer term, migrant and mobile FSWs from both rural and urban setting are likely to have an important role in local HIV transmission dynamics since a considerable number of them end up working in their place of origin, after a period of migration and mobility.

The study specifically looked into the sexual behavior of rural and urban FSWs in place of residence and most recent destinations they have visited. In multivariate analysis, an increase in a number of clients per day is significantly associated with the higher likelihood of migration of both rural and urban FSWs. To better understand the HIV risk and vulnerability, client volume and condom usage with different partners were examined based on their mobility status also. Findings suggest that rural migrant FSWs appear to be at higher risk, and around 83% of rural migrant FSWs entertained more than three clients a day as compared to just 11% of FSWs having similar client volume in place of residence. An average client volume for the rural migrant FSWs is 4 to 5 a day at the places of destination as compared to one or two clients in the village of origin. Also, some sexual acts are considerably high in place of destinations as compared to their place of residence.

Similarly, urban FSWs emerge as a relatively high-risk group and not found considerable differences in the client volume among non-migrant and migrant urban FSWs. Urban FSWs entertain an average 3 to 4 clients in place of residence and the destination as well. Also, they have the considerably high number of sex acts in a day. The Higher number of client volume and increased number of sexual acts in a stipulated period can considerably increase the chances of getting HIV among both rural and urban migrant FSWs. However, condom use data suggests that both rural migrant and urban migrant

and non-migrant FSWs may not have a riskier behavior per commercial sex transaction than rural non-migrant FSWs. Both rural migrant and all urban women consistently use condoms at a much higher level compared to rural non-migrant FSWs in place of residence. This may be because HIV intervention programs at urban towns within study districts and the different destinations in Maharashtra might have focused on condom promotion and condom social marketing. Additionally, there may be some social desirability bias in reporting condom use, with those working in a structured setting like brothel feeling pressure to reporting high condom use. However, condom use is extremely low with intimate partners for all groups of FSWs, and this study has not provided enough evidence for decreased condom use with intimate partners. Therefore, an in-depth study is suggested to better understand the condom use dynamics, especially with intimate partners and introducing innovative methods to empower FSWs to successfully negotiate condom use with their partners.

7.2 Conclusion and recommendations:

As stated earlier, migration is commonly identified as a key driver of HIV epidemic and playing a prominent role in the global regional and local spread of epidemic (Quinn TC, 1994; Webber, 2007). Specifically, female sex worker migration has been fuelling the countries HIV prevalence and the incidence. More importantly, as Alary and Lowndes mentioned (Alary & Lowndes, 2004), FSWs migration is not just playing a role in HIV transmission among different populations, but it also put FSWs themselves at heightened risk for HIV. This research has an important programmatic, research and policy implications. The information gained through this research about common destinations and mobility pattern of rural and urban FSWs would greatly help to plan and implement a specific HIV prevention program for both rural and urban FSWs. Also, these

findings could contribute greatly in positioning the service delivery system at both source and different destinations. Also, this study has rightly pointed out the scope for further research, which could significantly contribute to strengthening the existing programs for FSWs. It has also given an ample opportunity to introspect the current policies in the area of HIV Prevention approaches, which are targeting migrant and nonmigrant FSWs in both rural and urban setting across the country.

To provide possible programmatic implications for the HIV prevention programs with migrant FSWs, the study assessed the possible coverage of rural and urban FSWs at different town through a focus on specific destinations. Rural FSWs from Bagalkot, Belagavi and Vijayapura migrate to a very selective number of places and most of them are in Maharashtra. The study suggests that HIV prevention program in the study districts would cover more than 85% of rural migrant and mobile FSWs by targeting ten places in Maharashtra and Karnataka. Those ten places include Pune, Sangli, Mumbai, Bhiwandi, Kolhapur, Miraj, Karad in Maharashtra; Chikodi, Gokak in Belagavi district and Jamkhandi in Bagalkot district. Similarly, around 85% of urban migrant and mobile FSWs would be covered by targeting 12 cities, and all of them were located within study districts. Those 12 towns include Athani, Bailhongal, Belagavi, Chikodi, Gokak, Hukeri, Ramdurg, Raybag, and Savadatti in Belagavi district; Mudhol, Jamkhandi in Bagalkot district; and Vijayapura town in Vijayapura district. The study has also distinguished the coverage of migrant and mobile FSW by their district of origin. Around 85% of rural and 90% of urban FSWs from Belagavi district, who have been moving within and outside the districts, would be covered by focusing 13 towns (4 in Maharashtra & 9 in within study district). Similarly from Bagalkot, more than 90% of rural and around 80 of urban migrant and mobile

FSWs could be covered by focusing just nine towns (7 in Maharashtra and 2 in within study district). Also in Vijayapura, around 85% of rural and 90% of urban mobile and migrant FSWs could be covered by just focusing on six towns (3 in Maharashtra and 3 in within study district).

Furthermore, this study has given a comprehensive depiction of different destinations for migrant FSWs and indicates that most rural migrant FSWs work in brothels situated in clearly delimited and easily identifiable red light areas in Maharashtra. This makes the coverage of rural migrant FSWs, even more, feasible. But importantly, involving them for HIV prevention program is more challenging since most of them are under the control of different brothel owners at various destinations (Buzdugan et al., 2010; Buzdugan et al., 2009). So that the research findings suggest working closely with brothel owners and the FSW families to establish a trust for effective coverage, make them access to services and connect these women with the sex worker collectives in the places of origin and destination. This requires a more coordinated effort between different NGOs and CBOs working between source and destination and need to develop an implementation plan jointly. As part of an effective HIV prevention program, study also recommends to use audio-visual methods in an interpersonal communication with FSWs on educating HIV/AIDS, and this could be more effective considering the high level of illiteracy among them.

The higher mobility pattern of urban FSWs has heightened their HIV risk and raises a need for developing newer HIV prevention strategies. Some of the strategies for HIV prevention initiatives among urban FSWs could include; tracking their HIV risk behaviors along the routes of mobility, providing preventive messages and information on availability of program services in different locations

they visits, ensuring confidentiality and anonymity while providing services, helpline service to contact in an emergency situations, and mobilization of mobile FSWs community networks. Many of these recommendations were also suggested in other studies conducted elsewhere in India and proven effective to reach highly mobile FSWs (N. Saggurti, Jain, et al., 2012).

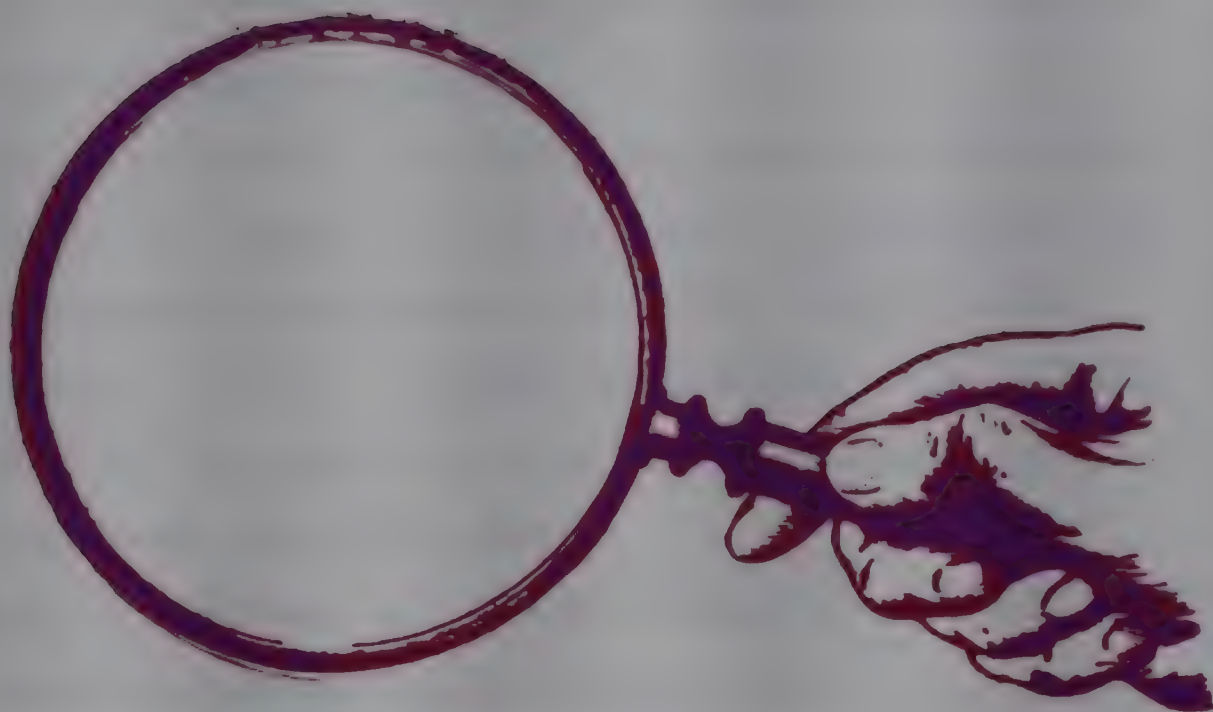
Study findings have also recommended few operational research studies to better understand and strengthen the ongoing HIV prevention efforts with FSWs in both source and destination districts. The present study found a huge gap in FSWs condom use behavior with their intimate partners and recommends an in-depth study to understand the condom use dynamics within the intimate relationship and suggests introducing different methods to empower FSWs along with including their male partners in HIV prevention effort to successfully negotiate condom use dynamics within the intimate relationship. Furthermore, the study found a high-risk period for FSWs when they first start sex work and recommended an operational research to better understand the pattern of condom use and service utilization among rural and urban FSWs in their early months after sex work initiation. Also, qualitative findings of this study have highlighted the most recent changes in *Devadasi* dedication and practices, and community-based ethnographic study could be conducted to document the most recent changes in *Devadasi* tradition and its impact on women's entry into sex work.

Lastly, study findings could be best utilized in planning and implementing the NACOs HIV prevention programs focusing on migrant populations in different migration corridor districts. Also, this could provide an opportunity to intersect the national guidelines to intervene with migrant population across the county.

7.3 Strengths and limitations:

The present research has strengths, and this could strongly contribute to the success of further such studies. Firstly, the involvement of peer community researchers and the local sex worker community-based organization for recruitment of study participants was an important highlight of this study, and it has greatly increased the response rate in the survey. Secondly, having an explanatory sequential design, applying both quantitative and qualitative approach has greatly contributed in investigating the hidden and stigmatized behavior of female sex worker and many social factors, which is underlying HIV epidemic. Thirdly, qualitative findings in light of quantitative data have significantly contributed in providing an external validity to the data through triangulation. Finally and certainly important, this study is first in its nature in providing the in-depth exploration of migration and mobility patterns of hidden and stigmatized population in this region.

Also, this study is not entirely free of limitations. Considering the legal implications, this study has excluded the FSWs, who are less than 18 years old, and their views and opinions are missing in this study. The study might have faced recall bias since most of the information on migration and mobility patterns, and related experiences were collected retrospectively. Lastly, the cross-sectional nature of this study cannot assess temporal sequence, and thus we cannot conclude that factors identified as being independently associated with migration are causes or results of migration.



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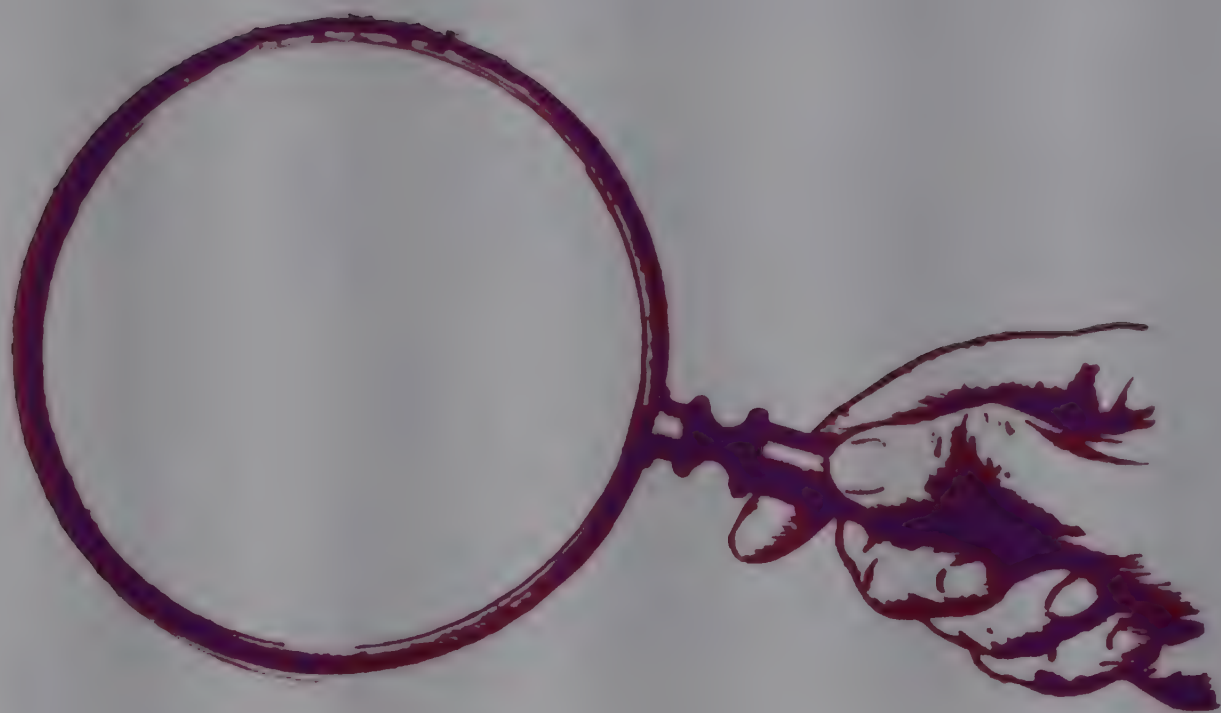
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APPENDIX

APPENDIX

Appendix 1: Percent distribution of FSWs by their socio demographic information according to place of residence

of residence		Characteristics		Rural				Urban				
				Migrant N=833 (%)	Nonmigrant N=728 (%)	Total N=1561 (%)	P§	Migrant N=584 (%)	Nonmigrant N=722 (%)	Total N=1306 (%)	P§	
Current age							<0.001					0.038
<25		466(55.9)	264(36.3)	730(46.8)				116(19.9)	118(16.3)	234(17.9)		
25-29		114(13.7)	134(18.4)	248(15.9)				156(26.7)	163(22.6)	319(24.4)		
30-34		126(15.1)	131(18)	257(16.5)				156(26.7)	199(27.6)	355(27.2)		
35-39		82(9.8)	130(17.9)	212(13.6)				108(18.5)	158(21.9)	266(20.4)		
40+		45(5.4)	69(9.5)	114(7.3)				48(8.2)	84(11.6)	132(10.1)		
No of participants from each study districts							0.036					0.075
Belgaum		216(25.9)	221(30.4)	437(28)				356(61)	396(54.8)	752(57.6)		
Bagalkot		491(58.9)	382(52.5)	873(55.9)				148(25.3)	205(28.4)	353(27)		
Vijayapura		126(15.1)	125(17.2)	251(16.1)				80(13.7)	121(16.8)	201(15.4)		
Religion							0.785					<0.001
Hindu		816(98)	712(97.8)	1528(97.9)				560(95.9)	656(90.9)	1216(93.1)		
Islam		16(1.9)	14(1.9)	30(1.9)				24(4.1)	65(9)	89(6.8)		
Christian		0(0)	0(0)	0(0)				0(0)	0(0)	0(0)		
Other		1(0.1)	2(0.3)	3(0.2)				0(0)	1(0.1)	1(0.1)		
Literacy (read & writes?)							0.936					0.125
No		673(80.8)	587(80.6)	1260(80.7)				413(70.7)	482(66.8)	895(68.5)		
Yes		160(19.2)	141(19.4)	301(19.3)				171(29.3)	240(33.2)	411(31.5)		

Highest level of schooling completed							0.928					0.473
Primary		97(11.6)	83(11.4)	180(11.5)				102(17.5)	129(17.9)	231(17.7)		
Higher primary		73(8.8)	58(8)	131(8.4)				57(9.8)	88(12.2)	145(11.1)		
High school & above		15(1.8)	17(2.3)	32(2)				36(6.2)	50(6.9)	86(6.6)		
Have not attended school		647(77.7)	569(78.2)	1216(77.9)				389(66.6)	454(62.9)	843(64.5)		
Mother tongue							0.109				0.005	
Kannada		801(96.2)	683(93.8)	1484(95.1)				539(92.3)	626(86.7)	1165(89.2)		
Hindi		6(0.7)	13(1.8)	19(1.2)				4(0.7)	14(1.9)	18(1.4)		
Marathi		20(2.4)	27(3.7)	47(3)				15(2.6)	21(2.9)	36(2.8)		
Other		6(0.7)	5(0.7)	11(0.7)				26(4.5)	61(8.4)	87(6.7)		
Current marital status							<0.001				0.955	
Currently married		30(3.6)	40(5.5)	70(4.5)				89(15.3)	117(16.2)	206(15.8)		
Separated		62(7.4)	56(7.7)	118(7.6)				102(17.5)	117(16.2)	219(16.8)		
Divorced		51(6.1)	15(2.1)	66(4.2)				46(7.9)	53(7.4)	99(7.6)		
Widowed		52(6.2)	84(11.5)	136(8.7)				114(19.6)	135(18.7)	249(19.1)		
Never married		14(1.7)	1(0.1)	15(1)				17(2.9)	24(3.3)	41(3.1)		
Devadasi		624(74.9)	532(73.1)	1156(74.1)				214(36.8)	275(38.1)	489(37.5)		
No of living children (own/biological)							<0.001				<0.001	
0		299(35.9)	126(17.3)	425(27.2)				127(21.7)	108(15)	235(18)		
1		241(28.9)	166(22.8)	407(26.1)				143(24.5)	169(23.4)	312(23.9)		
2		194(23.3)	240(33)	434(27.8)				184(31.5)	221(30.6)	405(31)		
3		99(11.9)	196(26.9)	295(18.9)				130(22.3)	224(31)	354(27.1)		

Appendix 2: Percent distribution of FSWs by their sex work profile according to place of residence

Appendix 2: Percent distribution of TSWs by their sex work profile									
Characteristics	Rural					Urban			
	Migrant N=833 (%)	Nonmigrant N=728 (%)	Total N=1561 (%)	P§	Migrant N=584 (%)	Nonmigrant N=722 (%)	Total N=1306 (%)	P§	
Duration in sex work				<0.001				0.002	
<2 yr	72(8.6)	29(4)	101(6.5)		48(8.2)	27(3.7)	75(5.7)		
2-4 yr	100(12)	78(10.7)	178(11.4)		84(14.4)	133(18.4)	217(16.6)		
5-9 yr	320(38.4)	217(29.8)	537(34.4)		254(43.5)	309(42.8)	563(43.1)		
10+ yr	341(40.9)	404(55.5)	745(47.7)		198(33.9)	253(35)	451(34.5)		
Age at sex work debut				0.122				0.305	
<18 yr	525(63)	437(60)	962(61.6)		126(21.6)	149(20.6)	275(21.1)		
18-24 yr	225(27)	193(26.5)	418(26.8)		277(47.4)	316(43.8)	593(45.4)		
25-29 yr	57(6.8)	60(8.2)	117(7.5)		121(20.7)	180(24.9)	301(23)		
30+ yr	26(3.1)	38(5.2)	64(4.1)		60(10.3)	77(10.7)	137(10.5)		
Main reason for coming into sex work				0.012				0.246	
I needed to meet my own financial needs	48(5.8)	40(5.5)	88(5.6)		103(17.6)	121(16.8)	224(17.2)		
I needed to meet my family's financial needs	416(49.9)	307(42.2)	723(46.3)		330(56.5)	391(54.2)	721(55.2)		
I was initiated into the devadasi tradition	348(41.8)	364(50)	712(45.6)		145(24.8)	193(26.7)	338(25.9)		
Other	21(2.5)	17(2.3)	38(2.4)		6(1)	17(2.4)	23(1.8)		
Monthly income from sex work				<0.001				<0.001	
<1000	141(16.9)	456(62.6)	597(38.2)		47(8)	92(12.7)	139(10.6)		
1000-2999	129(15.5)	191(26.2)	320(20.5)		179(30.7)	299(41.4)	478(36.6)		
3000-4999	200(24)	77(10.6)	277(17.7)		187(32)	227(31.4)	414(31.7)		
5000+	363(43.6)	4(0.5)	367(23.5)		171(29.3)	104(14.4)	275(21.1)		

Earnings from sex work contributed to household income			<0.001				0.306
All	447(53.7)	575(79)					
More than half	353(42.4)	142(19.5)					
Less than half	32(3.8)	10(1.4)					
Does someone else contribute to household income			0.162				0.034
No	160(19.2)	120(16.5)					
Yes	673(80.8)	608(83.5)					
Any other work apart from sex work							
No	662(79.5)	204(28)	<0.001				0.035
Yes	169(20.3)	522(71.7)					
Mobility status							
Local	0(0)	728(100)					
Mobile	190(22.8)	0(0)	<0.001				<0.001
Migrant	643(77.2)	0(0)					
Migration status							
Non migrant	0(0)	728(100)					
Migrant	833(100)	0(0)					

Source: from the field survey of this study.
 §P-value is for χ^2 test of independence comparing the place of residence.

Appendix 3: Percent distribution of FSWs by mobility patterns according to place of residence

Characteristics	Rural Migrant N= 833 (%)	Urban Migrant N= 584 (%)	Total N=1417 (%)	P ^s
Most recently migrated district				<0.001
Belgaum	163(19.6)	460(78.8)	623(44)	
Bijapur	21(2.5)	81(13.9)	102(7.2)	
Bombay	124(14.9)	4(0.7)	128(9)	
Goa	9(1.1)	1(0.2)	10(0.7)	
Kolhapur	40(4.8)	3(0.5)	43(3)	
Pune	191(22.9)	6(1)	197(13.9)	
Sangli	162(19.4)	10(1.7)	172(12.1)	
Satara	27(3.2)	2(0.3)	29(2)	
Thane	81(9.7)	1(0.2)	82(5.8)	
Other	15(1.8)	16(2.7)	31(2.2)	
Most recently migrated state				<0.001
Goa	8(1)	1(0.2)	9(0.6)	
Karnataka	190(22.8)	558(95.5)	748(52.8)	
Maharashtra	635(76.2)	25(4.3)	660(46.6)	
How old were you when first time visited this place				<0.001
12-15	146(17.5)	9(1.5)	155(10.9)	
16-18	196(23.5)	52(8.9)	248(17.5)	
19-25	351(42.1)	263(45)	614(43.3)	
25+	140(16.8)	260(44.5)	400(28.2)	
Who decided to visit this place at first time				<0.001
Own decision	458(55)	227(38.9)	685(48.3)	
Family	179(21.5)	51(8.7)	230(16.2)	
Pimp/broker	13(1.6)	3(0.5)	16(1.1)	
Friends	128(15.4)	219(37.5)	347(24.5)	
Client	36(4.3)	81(13.9)	117(8.3)	
Lover	17(2)	2(0.3)	19(1.3)	
Other	2(0.2)	1(0.2)	3(0.2)	

Usually who decides to visit this place				<0.001
Own decision	791(95)	535(91.6)	1326(93.6)	
Family	12(1.4)	15(2.6)	27(1.9)	
Pimp/broker	0(0)	0(0)	0(0)	
Friends	5(0.6)	25(4.3)	30(2.1)	
Client	21(2.5)	8(1.4)	29(2)	
Lover	3(0.4)	0(0)	3(0.2)	
Other	1(0.1)	1(0.2)	2(0.1)	
Where do you normally stay when you visit a destination?				<0.001
With friend	56(7)	52(16.9)	108(9.7)	
With relative	0(0)	0(0)	0(0)	
Brothel/ gharwali	536(66.8)	84(27.4)	620(55.9)	
Lodge	84(10.5)	73(23.8)	157(14.2)	
Other	10(1.2)	98(31.9)	108(9.7)	
Rented room/house	116(14.5)	0(0)	116(10.5)	

Source: from the field survey of this study.
[§]*P*-value is for χ^2 test of independence comparing the place of residence.

Appendix 4: Percent distribution of FSWs by their sexual behavior and HIV risk and vulnerabilities in place of residence according to place of residence

Characteristics	Rural				Urban			
	Migrant N=172 (%)	Non migrant N=728 (%)	Total N=900 (%)	P [§]	Migrant N=104 (%)	Non migrant N=721 (%)	Total N=825 (%)	P [§]
Main place of solicitation				0.079				<0.001
Home	128(74.4)	585(80.4)	713(79.2)		41(39.4)	283(39.3)	324(39.3)	
Lodge	0(0)	2(0.3)	2(0.2)		0(0)	15(2.1)	15(1.8)	
Brothel	1(0.6)	1(0.1)	2(0.2)		3(2.9)	54(7.5)	57(6.9)	
Street	33(19.2)	123(16.9)	156(17.3)		24(23.1)	241(33.4)	265(32.1)	
Other	10(5.8)	17(2.3)	27(3)		36(34.6)	128(17.8)	164(19.9)	
Source of clients				0.875				0.112
Independently	42(24.4)	178(24.5)	220(24.4)		52(50)	295(40.9)	347(42.1)	
Clients come on their own	113(65.7)	487(66.9)	600(66.7)		38(36.5)	342(47.4)	380(46.1)	
Other	17(9.9)	63(8.7)	80(8.9)		14(13.5)	84(11.7)	98(11.9)	
Main place of having sex				0.003				0.112
Home	133(77.3)	604(83)	737(81.9)		70(67.3)	480(66.6)	550(66.7)	
Lodge	3(1.7)	1(0.1)	4(0.4)		9(8.7)	97(13.5)	106(12.8)	
Brothel	1(0.6)	0(0)	1(0.1)		6(5.8)	61(8.5)	67(8.1)	
Other	35(20.3)	123(16.9)	158(17.6)		19(18.3)	83(11.5)	102(12.4)	
No of clients per day				<0.001				<0.001
1	77(44.8)	415(57)	492(54.7)		6(5.8)	12(1.7)	18(2.2)	
2	60(34.9)	246(33.8)	306(34)		55(52.9)	280(38.8)	335(40.6)	
3+	35(20.3)	67(9.2)	102(11.3)		43(41.3)	429(59.5)	472(57.2)	

Why did you use condoms every time with Paying & Regular Clients?					0.991				0.039
Afraid of HIV/AIDS		99(94.3)	462(94.5)	561(94.4)		87(97.8)	512(91.6)	599(92.4)	
Other		5(4.8)	22(4.5)	27(4.5)		1(1.1)	2(0.4)	3(0.5)	
Don't trust him/them		1(1)	5(1)	6(1)		1(1.1)	45(8.1)	46(7.1)	
Reason for not regularly using condoms with Paying & Regular Clients?					0.268				0.61
I trust them		5(12.2)	34(21.7)	39(19.7)		2(16.7)	6(8.5)	8(9.6)	
They refuse		18(43.9)	53(33.8)	71(35.9)		7(58.3)	34(47.9)	41(49.4)	
Don't have condoms		3(7.3)	22(14)	25(12.6)		0(0)	0(0)	0(0)	
More money		8(19.5)	15(9.6)	23(11.6)		2(16.7)	20(28.2)	22(26.5)	
Other		6(14.6)	28(17.8)	34(17.2)		1(8.3)	11(15.5)	12(14.5)	
Regular condom use with non-paying partners					0.12				0.017
Every time		42(20.7)	104(21.6)	146(21.3)		44(21.3)	81(20.7)	125(20.9)	
Most of the time		15(7.4)	45(9.4)	60(8.8)		17(8.2)	24(6.1)	41(6.9)	
Some of the time		17(8.4)	70(14.6)	87(12.7)		48(23.2)	56(14.3)	104(17.4)	
Not used		128(63.1)	261(54.3)	389(56.9)		98(47.3)	230(58.8)	328(54.8)	
Reason for regular condom use with paying and new/occasional clients					0.31				0.416
Afraid of HIV/AIDS		32(76.2)	73(70.2)	105(71.9)		41(93.2)	73(90.1)	114(91.2)	
Other		2(4.8)	14(13.5)	16(11)		2(4.5)	2(2.5)	4(3.2)	
Don't trust him/them		8(19)	17(16.3)	25(17.1)		1(2.3)	6(7.4)	7(5.6)	
Main reason for not regularly using condoms with non-paying partners					0.102				0.677
I trust them		94(58.8)	220(58.5)	314(58.6)		90(55.2)	175(56.5)	265(56)	
They refuse		33(20.6)	81(21.5)	114(21.3)		52(31.9)	90(29)	142(30)	
Want to get pregnant		25(15.6)	36(9.6)	61(11.4)		4(2.5)	12(3.9)	16(3.4)	
Don't like it		4(2.5)	14(3.7)	18(3.4)		3(1.8)	11(3.5)	14(3)	
Other		4(2.5)	25(6.6)	29(5.4)		14(8.6)	22(7.1)	36(7.6)	

Appendix 5: Percent distribution of FSWs by their sexual behaviour and HIV risk and vulnerabilities in most recent place of visit according to place of residence

Characteristics	Rural Migrant N=833 (%)	Urban Migrant N=582 (%)	Total N=1415 (%)	P [§]
Where do you get clients				<0.001
Home	142(17)	60(10.3)	202(14.3)	
Lodge	34(4.1)	60(10.3)	94(6.6)	
Brothel	416(49.9)	93(16)	509(36)	
Street	209(25.1)	291(50)	500(35.3)	
Other	32(3.8)	78(13.4)	110(7.8)	
How do you mainly get clients				<0.001
Independently	350(42)	310(53.3)	660(46.6)	
Clients come on their own	431(51.7)	233(40)	664(46.9)	
Other	52(6.2)	39(6.7)	91(6.4)	
Where do you normally have sex with clients				<0.001
Home	174(20.9)	199(34.2)	373(26.4)	
Lodge	99(11.9)	247(42.4)	346(24.5)	
Brothel	546(65.5)	124(21.3)	670(47.3)	
Other	14(1.7)	12(2.1)	26(1.8)	
No of clients per day				<0.001
1	54(6.5)	4(0.7)	58(4.1)	
2	86(10.3)	117(20.1)	203(14.3)	
3+	693(83.2)	461(79.2)	1154(81.6)	
No of sex acts per day				<0.001
1	37(4.4)	0(0)	37(2.6)	
2	72(8.6)	67(11.5)	139(9.8)	
3+	724(86.9)	515(88.5)	1239(87.6)	
Regular condom use with clients				0.029
Every time	770(97.6)	530(99.6)	1300(98.4)	
Most of the time	9(1.1)	1(0.2)	10(0.8)	
Some of the time	7(0.9)	0(0)	7(0.5)	
Not used	3(0.4)	1(0.2)	4(0.3)	
Reason for regular condoms use with Client				0.013
Afraid of HIV/AIDS	729(94.7)	507(95.7)	1236(95.1)	
To prevent STI/STD	16(2.1)	0(0)	16(1.2)	
To avoid pregnancy	2(0.3)	1(0.2)	3(0.2)	
Don't trust him/them	21(2.7)	22(4.2)	43(3.3)	
Reason for not regularly using condoms with Clients?				0.156
More money	10(52.6)	0(0)	10(47.6)	
Other	9(47.4)	2(100)	11(52.4)	

Regular condom use with regular clients				0.027
Every time	653(90.8)	490(93.9)	1143(92.1)	
Most of the time	48(6.7)	30(5.7)	78(6.3)	
Some of the time	7(1)	1(0.2)	8(0.6)	
Not used	11(1.5)	1(0.2)	12(1)	
Reason for regular condom use with Regular Clients				<0.001
Afraid of HIV/AIDS	629(96.3)	464(94.7)	1093(95.6)	
To prevent STI/STD	11(1.7)	0(0)	11(1)	
To avoid pregnancy	3(0.5)	2(0.4)	5(0.4)	
Don't trust him/them	9(1.4)	24(4.9)	33(2.9)	
Other	1(0.2)	0(0)	1(0.1)	
Main reason for not regularly using condoms with Regular Clients?				0.091
I trust them	12(18.2)	0(0)	12(12.2)	
They refuse	15(22.7)	10(31.3)	25(25.5)	
More money	27(40.9)	18(56.3)	45(45.9)	
Other	8(12.1)	4(12.5)	12(12.2)	
Regular condom use with Intimate partner				0.338
Every time	44(28.9)	30(32.3)	74(30.2)	
Most of the time	8(5.3)	8(8.6)	16(6.5)	
Some of the time	17(11.2)	5(5.4)	22(9)	
Not used	83(54.6)	50(53.8)	133(54.3)	
Why did you use condoms every time with Intimate Partner				0.704
Afraid of HIV/AIDS	39(88.6)	27(90)	66(89.2)	
To prevent STI/STD	1(2.3)	0(0)	1(1.4)	
To avoid pregnancy	0(0)	0(0)	0(0)	
Don't trust him/them	4(9.1)	3(10)	7(9.5)	
Other	0(0)	0(0)	0(0)	
Main reason for not regularly using condoms with Intimate Partners				0.202
I trust them	68(63)	39(61.9)	107(62.6)	
They refuse	19(17.6)	17(27)	36(21.1)	
Want to get pregnant	19(17.6)	5(7.9)	24(14)	
Other	2(1.9)	2(3.2)	4(2.3)	
Have you ever had sex in a group?				0.175
No	828(99.4)	579(100)	1407(99.6)	
Yes	4(0.5)	0(0)	4(0.3)	
Have you ever been forced to have sexual intercourse?				<0.001
No	807(96.9)	523(90.6)	1330(94.3)	
Yes	25(3)	53(9.2)	78(5.5)	

Have you been physically abused by your client?				<0.001
No	803(96.4)	542(93.6)	1345(95.3)	
Yes	29(3.5)	37(6.4)	66(4.7)	
Have you faced harassment or physical abuse by the police				0.028
No	670(80.4)	506(87.4)	1176(83.3)	
Yes	157(18.8)	73(12.6)	230(16.3)	
Have you ever been arrested?				0.001
No	757(90.9)	534(92.2)	1291(91.4)	
Yes	74(8.9)	45(7.8)	119(8.4)	

Source: from the field survey of this study.
[§]*P*-value is for χ^2 test of independence comparing the place of residence.

Appendix 6: FSWs mapping in northern Karnataka

The mapping was conducted as part of the India-Canada Collaborative HIV/AIDS Project (ICHAP) and collaboratively with the Karnataka Health Promotion Trust (KHPT). In the three study districts, all villages were included in the rural mapping: Belgaum (1255 villages), Bagalkot (629 villages) and, Bijapur (660 villages). Each village was visited by a field team consisting of one researcher and a member from the FSW community. Every three such teams were under the supervision of a Supervisor, who planned the day-to-day activities of the teams. In addition, the field-work in each district was assisted by one or two Regional Resource Persons (RRPs) and a team of 3 consultants from Population Research Centre, Dharwad. The field teams were trained for a period of 3 days, including field practice and feedback.

The field procedures are summarized below:

- The field team visited the village, met any of the available village leaders, introduced the team members, outlined the objectives of the visit, and made a list of available key informants in the village. In Bagalkot, a team of link workers and members of the local FSW collective collected the data on the number of FSWs in the village. In other districts, the study team carried out interviews with a minimum 5 of the following key informants (KIs) in the village: office-bearer of the Gram Panchayat, anganwadi teacher, ANM, school teacher, owners of petty shops/ grocery stores/ fair price shops/ hotels/tea stalls, members of Mahila Mandals, Sthree Shakti groups, members of Yuvak Mandals, local STD/Telephone booth operators, and people living with HIV+.

- The FSW member of the team visited the Janata Plot, Harijan Keri or the most vulnerable parts of the village, met with the women in these areas, introduced herself as a sex worker, explained the purpose of visit, and enquired whether there were any women in the village who engaged in sex work like her.
- If FSWs were reported in the villages, she met a maximum of 3 FSWs and collected information related to sex work in the village.
- The non-community member of the team met the other key informants in the village, and obtained the remaining information.
- The team triangulated the information from key informant interviews and completed the village form.

Information on the following indicators was collected for each village during the KI interviews:

1. Population of the village (as per the 2001 Census).
2. Are there any female sex workers staying in the village? A female sex worker is defined as a woman who has sold sex during the last one month. The following persons were not be considered as FSWs: (a) those who were sex workers but now have stopped sex work (b) the *Devadasis* who do not practice sex work and (c) those who have “casual” multiple partners.
3. How many female sex workers stay in the village? Based on all the key informant interviews, the number of FSWs who stay in the village is recorded. This is not the average of the number reported by each key informant, but a number the field team arrives at after triangulating the information obtained by the key informants. This number has two components: (a) those who practice sex work in the village and (b) those who live in

the village but do sex work outside the village (for instance, a woman who does not practice sex work in the village but goes to the nearest town/village daily/occasionally and practices sex work there).

4. Among all the sex workers who live in the village, how many are *Devadasis*? *Devadasis* who are not currently engaged in sex work are not considered here.

How many FSWs from this village live and practice sex work outside the village? Based on all the key informant interviews, the number of FSWs from the village who lives and practice sex work outside the village is recorded. This is not the average of the number reported by each key informant, but a number the team arrives at after triangulating the information obtained by the key informants. For instance, a woman who has migrated outside the village to a nearby or distant town, stays there and practices sex work is included here. The reference period for this information is 6 months. This number is the sum of the following three categories: (a) those who have migrated to do sex work within the district, (b) those who have migrated to do sex work outside the district but within the state, and (c) those who have migrated to do sex work outside the state.

Appendix 7: Information and consent form for qualitative interviews

You are being asked to participate in qualitative research project. Please take your time to review this consent form and discuss any questions you may have with the investigator or translator. You may take your time to make your decision about participating in this interview and you may discuss it with your friends or family before you make your decision. This consent form may contain words that you do not understand. Please ask the investigator to explain any words or information that you do not clearly understand.

Purpose of study:

This interview is being conducted to understand various aspects of sex work, the migration of rural female sex workers and the impact of this migration on HIV risk and vulnerability and transmission dynamics in northern Karnataka and southern Maharashtra. This may allow us to improve programs and services to prevent HIV/AIDS in this population. To help us to do so, we wish to interview sex workers both at the place of origin in Karnataka and at destination places in Maharashtra.

Study procedures:

In this study, we will be asking you a number of questions related to sex work, sex partners, migration, HIV/AIDS and condoms etc. Some of the questions will be related your personal life and may be asked to describe aspects of sexual behavior. You will be asked to participate in the in-depth interview (II) or Focus Group Discussion (FGD) Or both.

A) In-depth Interviews (II):

In-depth Interview will take place between you (study participant) and the interviewer. The interviews will take place in the language of your choice. The interview will be tape (audio) recorded and then

transcribed. If you do not agree to record the interview, we will make notes of the interview.

The interviews transcripts will be entered into a computer. We would like to assure you that all information you provide in this interview will be kept strictly confidential and will only be used to create a general picture of health. The interview will be approximately one hour long.

B) Focus Group Discussion :

Focus Group Discussion (FGD) is group interview, the interviewer will moderate the Discussion and there will be more than two participants other than you. The discussion will take place in the language of your choice. The interview will be tape (audio) recorded and then transcribed. If you do not agree to record the interview, we will make notes of the discussion.

The discussion transcripts will be entered into a computer. We would like to assure you that all information you provide in this interview will be kept strictly confidential and will only be used to create a general picture of health. The interview will be approximately one hour long.

Risks and Discomforts:

There is minimal risk for participating in this study. You may feel uncomfortable, embarrassed, or stressed when discussing certain topics that come up in the interview. We assure you again the confidentiality of the information provided.

Benefits:

There may or may not be direct benefit to you from participating in this study. It is hoped that the information learned from this study will

help us develop more effective HIV/AIDS prevention services for your community.

Costs:

All activities of this study are provided at no cost to you.

Payment for participation:

You will receive no payment for your participation in this study.

Confidentiality:

Information gathered in this research study may be published or presented in public forums, but your name will not be used or revealed. Every effort will be made to protect your anonymity. Despite efforts to keep your personal information confidential, absolute confidentiality cannot be guaranteed. Your personal information may be disclosed if required by law.

Voluntary participation/withdrawal from the study:

Your decision to take part in this part of the study is voluntary. You may refuse to participate or you may withdraw at any time. Your decision to not participate or to withdraw from the study will not affect your health care in any way. If the study staff feels that it is in your best interest to withdraw you from the study, they will remove you without your consent.

You are not waiving any of your legal rights by signing this consent form or releasing the investigator or the sponsor from their legal and professional responsibilities.

You will be informed about any new information that may affect or useful your health, welfare, or willingness to stay in this study.

Questions:

You are free to ask any questions that you may have about the study and your rights as a research participant. If any questions come up during or after the study, you can contact Mr. Satyanarayana (9972577910).

Do not sign this consent form unless you have had a chance to ask questions and have received satisfactory answers to all of your questions.

I agree to participate in the In-depth Interview (II)

YES: ☐

NO ☐

Printed Name of Participant: _____

Signature/Thumb Impression of Participant: _____

I agree to participate in the Focus Group Discussion(FGD).

YES: ☐

NO ☐

Printed Name of Participant: _____

Signature/Thumb Impression of Participant: _____

I, the undersigned, have fully explained relevant details of this research study to the participant named above and believe that the participant has understood. Furthermore, the participant has knowingly given her consent.

Printed Name of Interviewer: _____

Signature of Interviewer: _____

Appendix 8: Qualitative In-depth Interview Guide & Subject Areas

Introduction:

Note: Many of the following questions are very sensitive and personal. Please say pass if you are feeling uncomfortable any point and I will move on to another question.

1. Can you tell us about life of women who practice this business (sex work)?

Initiation and Life Stage:

2. Can you tell me about any changes in this business that has occurred in the last 5-10 years?
3. Tell me the story of your life and when you began to do this business? How were you feeling then?
4. Tell me your experience, in the very beginning that is first 5 months you were into sex work?
5. Tell me the challenges that you had in your work at the beginning
6. Do you have those challenges/problems now? If not, why?
7. If you still have those problems, then how are you dealing with them? Do you think any of these challenges are unique or most difficult for new sex workers?
8. Can you describe how Devadasis are initiated into sex work? Who decides?
9. What are the advantages and disadvantages of being initiated into sex work through Devadasi tradition?

Environment:

10. Do you practice this work only in your own village/town? If not, what are the places that you go to do this work?
11. Have you ever gone to places outside your state/district (e.g. Maharashtra)? If no, why do you NOT go to the places outside your state/district?
12. Where do you practice sex work? Do you NOT practice this work only in your own village? If no, what are the places that you go to do this work?
13. What are the difficulties that you face in doing this business in the places that you do business?
14. Where/how do you get clients in these places?
15. Where do you have sex with clients in those places?
16. Is it easy to get condoms at all the places you practice this business?

17. Who are those people who have control over your life and work and how do they control you?
18. Is there any changes happened in the past 5-10 years in these control aspects, if yes, what are those changes?

Clients/Sexual Partners:

19. What are all the different kinds of sexual partners that women doing this work have? Please describe each kind.
20. What are the different types of sexual partners that you have? Please describe.
 - a. In what way are repeat clients different from new/occasional clients and other sex partners?
21. Do you have any problems in any of your relationships? Explain.
22. Do you do the same sexual practice in each sexual relationship? Explain why or why not.
23. Please talk about the difficult clients? How do you handle them?
24. Which relationships are easy to negotiate condoms? Which ones are difficult to negotiate condoms? Why?

Attitude toward Condoms:

25. When did you first hear about condoms? How did you hear about them? What did you think about this at that time?
26. After how many years into sex work, you started using condoms without any hesitation?
27. At the beginning, when you first started using condoms, did you have any difficulties (with breakage, condom slipping off, discomfort etc)?
28. In the beginning, how did clients react when you tried to get them to wear condoms?
29. What is the situation now? Where do you get condoms from?
30. What is your preferred source (condoms from Pharmacy, Local NGOs, and Clients)?
 - a. Why do you prefer these ones?

Accessing Health Resources:

31. What kinds of places do you access when you are having health problems? Has anyone ever mistreated you at these places because of the business that you practice?
32. What is your experience of accessing HIV-related services? Please tell me your likes and dislikes.
33. Are you aware of any sex worker's collectives? Do you take part in any of their programs or activities?
 - a. What do you expect from this kind of collective?
34. Are you part of any women's groups? Explain.

Appendix 9: Focus Group Discussion (FGD) Guide & Subject Areas

For migrant sex workers

Changes in Migration of women:

1. What are the changes that have occurred in the past 5-10 years about the migration of sex workers from N. Karnataka to Maharashtra?

First experience as a migrant:

2. How the first visit was is decided and planned?
3. When new and young sex workers from villages go to cities/towns in Maharashtra for the first time, how do they adjust there and do they experience any difficulties?

Facilitators of migration:

4. Who plays a major role in this movement (e.g, Gharwali/ brothel madam, family members, agents etc)? Please explain.
5. Do they who go on loans or contract? explain

HIV related services:

6. Please talk about HIV related services and condoms in the places that you go in Maharashtra?
7. What are the difficulties you face in accessing services there?

For non-migrant Sex Workers

Changes in Migration of women:

1. What are the changes that have occurred in the past 5-10 years about the migration of sex workers from N. Karnataka to Maharashtra?

Perceptions about migration and migrant sex workers:

2. Why some women go to other places outside the district/ state for sex work? And why some women do not go to other places outside the district and state for sex work?
3. What are the difference to see between the women who go to other place for sex work and the women who do not go to other places for sex work?
4. What are the benefits of women going and working outside the district Vs women not working at their native places?

Appendix 10: Companion sheets for focus group discussion

Archival #: _____ Site: _____

Date:

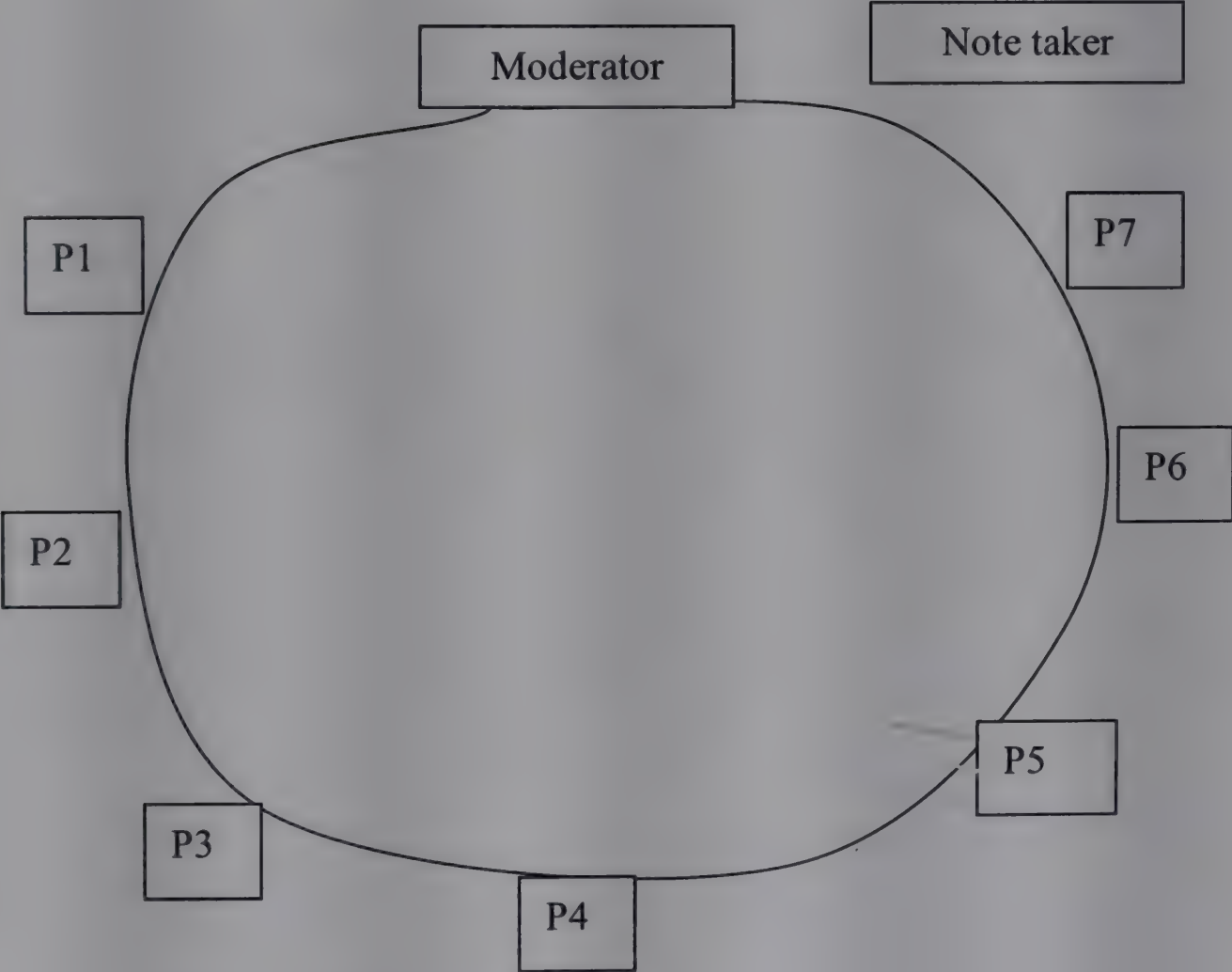
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 Focus Group Category: _____

Start Time: _____ End Time: _____

Moderator: _____ Note-taker: _____

Seating Chart: Make a seating chart indicating the participants and their number or identifier. Use this chart to identify speakers as you take notes.



Companion Sheet for Focus Group Discussion with FSWs

Archival #:

Date:

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Question (# or keyword)	Notes and Observations

Debriefing Form for Focus Group Discussion with FSWs

Archival #: _____ Site: _____

Date:

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 Focus Group Category: _____

Start Time: _____ End Time: _____

Moderator: _____ Note-taker: _____

1. What are the main themes that emerged in this focus group?
2. Did any information contradict what you have learned so far in quantitative survey?
3. What problems did you encounter (e.g., logistical, behaviors of individuals, questions that were confusing, etc.)?
4. What issues would you like to follow up on in future FGDs or interviews?
5. Other notes, observations (especially those that would not be evident from reading a transcript of the discussion e.g., group dynamic, individual behaviours, etc.):

Appendix 11: Quantitative survey questioner

SECTION I: INTERVIEW INFORMATION

Locale ID (District Code + Taluk Code).....		
Village ID.....		
Respondent ID... (First 3 letters of respondent's first name)		
Respondent ID Nu.....		
Migrant Cohort Member (YES=1, NO=0).....		
Participant interviewed in district other than place of residence (YES=1, NO=0).....		
Consented for interview (YES=1, NO=0).....		
Date of interview: DAY... MONTH... YEAR...		
Result of interview: (Interview completed=1, Interview partially completed=2, Respondent refused to participate=3, Respondent was a duplicate=4).....		
<u>Data:</u>		
Coded By:.....		
Checked By:.....		
Entered		

SECTION II: SOCIO-DEMOGRAPHIC CHARACTERISTICS

No.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
1	Do you normally live in this village/town/city? If 'YES', record information on her residence and then SKIP to Q3.	YES.....1 → Q3 VILLAGE/TOWN/CITY _____ TALUK _____ DISTRICT _____ STATE _____ NO.....0	
2	If 'NO', then where do you live?	VILLAGE/TOWN/CITY _____ TALUK _____ DISTRICT _____ STATE _____	
3	How long have you been staying where you currently live? Record in months if less than one year. Otherwise record in complete years.	MONTHS..... YEARS.....	
4	How old were you on your last birthday? Probe and estimate if not known. **If less than 18 years of age, TERMINATE the interview.	AGE IN COMPLETE YEARS.... DON'T KNOW.....88	
5	What religion do you practice?	HINDUISM.....1 ISLAM.....2 CHRISTIANITY.....3 OTHER _____ 4 (SPECIFY) NO RESPONSE.....99	
6	What is your caste? Record verbatim.	CASTE _____ DON'T KNOW.....88 NO RESPONSE.....99	
7	Can you read and write?	YES.....1 NO.....0	
8	What is the highest level of school that you have completed: primary, secondary, PUC, or higher? Record one response.	PRIMARY.....1 HIGHER PRIMARY.....2 HIGH SCHOOL.....3 PUC.....4 HIGHER.....5 HAVEN'T ATTENDED.....6 NO RESPONSE.....99	Q10

SECTION II: SOCIO-DEMOGRAPHIC CHARACTERISTICS

No.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKI
9	What is the highest (grade/class) that you have completed at that level?	GRADE/CLASS.....	
10	a. Do you speak the following languages? Record all mentioned. _____ b. What is your mother tongue? Record one response.	KANNADA.....A HINDI.....B MARATHI.....C TELUGU.....D ENGLISH.....E OTHER_____F (SPECIFY) _____ KANNADA.....1 HINDI.....2 MARATHI.....3 TELUGU.....4 OTHER_____5 (SPECIFY)	
11	What is your current marital status?	CURRENTLY MARRIED.....1 SEPARATED.....2 DIVORCED.....3 WIDOWED.....4 NEVER MARRIED.....5 DEVADASI.....6 NO RESPONSE.....99	} Q16
12	How old were you when you first married? Probe and record in years. If less than 12 months, record '00'.	YEARS..... DON'T KNOW.....88	
13	CHECK Q11 AND MARK	CURRENTLY MARRIED.....1 SEPARATED/DIVORCED.....2 WIDOWED.....3	→ Q16 → Q14 → Q15
14	How long ago were you separated/divorced? Record in months if less than one year. Otherwise record in complete years. Record '00' in months if less than one month.	MONTHS..... YEARS..... NO RESPONSE.....99	} Q16

SECTION II: SOCIO-DEMOGRAPHIC CHARACTERISTICS

No.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKI
15	How long ago did your husband die? Record in months if less than one year. Otherwise record in complete years. Record '00' in months if less than one month.	MONTHS..... YEARS..... NO RESPONSE.....99	
16	Which statement best describes your <u>current</u> relationship and living status? **For married women 'Regular Partner' SHOULD NOT include her husband. Read responses and record only one.	I HAVE: A REGULAR SEX PARTNER AND HE LIVES WITH ME.....1 A REGULAR SEX PARTNER AND HE DOESN'T LIVE WITH ME.....2 DON'T HAVE A REGULAR SEX PARTNER.....3 NO RESPONSE.....99	Q18
17	How long have you been living with this person? Record in months if less than one year. Otherwise record in complete years. Record '00' in months if less than one month.	MONTHS..... YEARS.....	
18a	Are you using any family planning methods?	YES.....1 NO.....0	Q19
18b	If 'YES', what are those? Do not read responses. Record all mentioned.	PILL.....A CONDOM.....B LOOP/COPPER T.....C FEMALE STERILIZATION.....D MALE STERILIZATION.....E RHYTHM/SAFE PERIOD.....F WITHDRAWAL.....G OTHER.....H (SPECIFY) DON'T KNOW.....88 NO RESPONSE.....99	
19	How many living children (own/biological) do you have?	NUMBER OF CHILDREN.....	
20	How many children do you support financially? Include biological, adopted, nieces, nephews, etc	NUMBER SUPPORTED BY HER..	

SECTION II: SOCIO-DEMOGRAPHIC CHARACTERISTICS

No.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
21	Including yourself, how many people are in your household?	TOTAL NUMBER.....	
22	What is your <u>monthly</u> household income?	RECORD INCOME...	

SECTION III: BACKGROUND ON SEX WORK

Now I will ask you some questions which will be sensitive in nature. It is important for us to collect this information from you. Please be assured that your answers will remain strictly confidential. Please let me know if you do not want to answer any of these questions.

No.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
23	a. How long have you been doing sex work? b. How old were you when you began sex work? Record in months if less than one year. Otherwise record in complete years. Record '00' in months if less than one month.	MONTHS..... YEARS..... AGE..... DON'T KNOW.....88	
24	Which statement best describes the <u>main</u> reason why you began to do sex work? Read each option once and then ask the participant to choose the one that best describes her situation. Record one response.	I GOT INTO SEX WORK BECAUSE: I NEEDED TO MEET MY OWN FINANCIAL NEEDS.....1 I NEEDED TO MEET MY FAMILY'S FINANCIAL NEEDS.....2 I WAS INITIATED INTO THE DEVADASI TRADITION.....3 I WAS TRICKED OR FORCED INTO IT (OTHER THAN TRAFFICKED).....4 I WAS TRAFFICKED INTO IT.....5 OTHER.....6 (SPECIFY) DON'T KNOW.....88 NO RESPONSE.....99	
25	How much money do you earn <u>per month</u> from sex work?	RECORD INCOME.....	
26	How much of your earnings from sex work contribute to your total household income?	ALL.....1 MORE THAN HALF.....2 LESS THAN HALF.....3	

SECTION III: BACKGROUND ON SEX WORK

No.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
27	Does someone else contribute to your household income?	YES.....1 NO.....0	→ Q29
28	Who else contributes to your household income? Do not read responses. Record all mentioned.	LOVER.....A HUSBAND.....B FATHER.....C BROTHER.....D MOTHER.....E OTHER _____ F (SPECIFY)	
29	Apart from sex work, do you do any other work to earn income?	YES.....1 NO.....0	

SECTION IV: DIFFERENTIATING BETWEEN MIGRATING AND NON-MIGRATING (FILTERS)

Now we will speak about whether you have migrated to other places for sex work. I want to remind you again that your answers will remain strictly confidential.

No.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
30	Were you born in this village/town/city (locale mentioned in either Q1 or Q2)?	YES.....1 NO.....0	→ Q32
31	If no, where were you born?	VILLAGE/CITY/TOWN _____ TALUK _____ DISTRICT _____ STATE _____	
32	Do you do sex work in this/your village (locale mentioned in either Q1 or Q2)?	YES.....1 NO.....0 NO RESPONSE.....99	
33	Have you <u>ever</u> gone to other places within the district (locale mentioned in either Q1 or Q2) for sex work?	YES.....1 NO.....0 NO RESPONSE.....99	} Q36
34	In the <u>past one year</u> , have you gone to other places within the district (locale mentioned in either Q1 or Q2) for sex work?	YES.....1 NO.....0 NO RESPONSE.....99	} Q36
35	How long did you stay when you went to other places within the district (locale mentioned in either Q1 or Q2) for sex work in the <u>past one year</u> ? Probe to find out the maximum amount of time she stayed in other places within her district.	LESS THAN 2 WEEKS.....1 MORE THAN 2 WEEKS.....2 DON'T KNOW.....88 NO RESPONSE.....99	

**SECTION IV: DIFFERENTIATING BETWEEN MIGRATING AND
NON-MIGRATING (FILTERS)**

No.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
36	Are you planning to go to other places within the district (locale mentioned in either Q1 or Q2) for sex work in the <u>next three months</u> ?	YES.....1 NO.....0 DON'T KNOW.....88 NO RESPONSE.....99	
37	Have you <u>ever</u> gone to another district or state (outside the locale mentioned in either Q1 or Q2) for sex work?	YES.....1 NO.....0 NO RESPONSE.....99	} Q40
38	In the <u>past one year</u> , have you gone to another district or state (outside the locale mentioned in either Q1 or Q2) for sex work?	YES.....1 NO.....0 NO RESPONSE.....99	
39	How long did you stay when you went to another district or state (outside the locale mentioned in either Q1 or Q2) for sex work in the <u>past one year</u> ? Probe to find out the maximum amount of time she stayed outside her district and/or state.	LESS THAN 2 WEEKS.....1 MORE THAN 2 WEEKS.....2 DON'T KNOW.....88 NO RESPONSE.....99	
40	Are you planning to go to another district or state (outside the locale mentioned in either Q1 or Q2) for sex work in the <u>next three months</u> ?	YES.....1 NO.....0 DON'T KNOW.....88 NO RESPONSE.....99	
41	CHECK Q34, Q35, Q38, Q39 AND MARK ALSO CHECK Q33 & Q37 (if needed)	Q34=1&Q35=1&Q38=1&Q39=1.....MOBILE(1) Q34=1&Q35=2&Q38=1&Q39=1.....MOBILE(2) Q34=1&Q35=1&Q38=1&Q39=2.....MIGRANT(3) Q34=1&Q35=2&Q38=1&Q39=2.....MIGRANT(4) Q34=1&Q35=1&Q38=0.....MOBILE(5) Q34=1&Q35=2&Q38=0.....MOBILE(6) Q34=0&Q38=1&Q39=1.....MOBILE(7) Q34=0&Q38=1&Q39=2.....MIGRANT(8) Q34=0&Q38=0.....LOCAL(9)* Q33=0&Q37=0.....LOCAL(10)*	

***FOR THOSE CODED AS LOCAL, SKIP TO SECTION VI**

**SECTION V: PATTERNS AND DETERMINANTS OF MOBILITY
(MIGRANT AND MOBILE WOMEN)**

42	List all the places that you have gone to in the last one year, beginning with the most recent one?		
	Places	Duration of Stay	Active Sex Work?
42a	VILLAGE/CITY/TOWN _____	DAYS.....	YES.....1
	TALUK _____	MONTHS.....	NO.....0
	DISTRICT _____	YEARS.....	
	STATE _____	Record in days if less than one month. Otherwise record in complete months or years.	
42b	VILLAGE/CITY/TOWN _____	DAYS.....	YES.....1
	TALUK _____	MONTHS.....	NO.....0
	DISTRICT _____	YEARS.....	
	STATE _____	Record in days if less than one month. Otherwise record in complete months or years.	
42c	VILLAGE/CITY/TOWN _____	DAYS.....	YES.....1
	TALUK _____	MONTHS.....	NO.....0
	DISTRICT _____	YEARS.....	
	STATE _____	Record in days if less than one month. Otherwise record in complete months or years.	
42d	VILLAGE/CITY/TOWN _____	DAYS.....	YES.....1
	TALUK _____	MONTHS.....	NO.....0
	DISTRICT _____	YEARS.....	
	STATE _____	Record in days if less than one month. Otherwise record in complete months or years.	

**SECTION V: PATTERNS AND DETERMINANTS OF MOBILITY
(MIGRANT AND MOBILE WOMEN)**

	Places	Duration of Stay	Active Sex Work?
42e	VILLAGE/CITY/TOWN _____ TALUK _____ DISTRICT _____ STATE _____	DAYS..... MONTHS..... YEARS..... Record in days if less than one month. Otherwise record in complete months or years.	YES.....1 NO.....0
42f	VILLAGE/CITY/TOWN _____ TALUK _____ DISTRICT _____ STATE _____	DAYS..... MONTHS..... YEARS..... Record in days if less than one month. Otherwise record in complete months or years.	YES.....1 NO.....0
42g	VILLAGE/CITY/TOWN _____ TALUK _____ DISTRICT _____ STATE _____	DAYS..... MONTHS..... YEARS..... Record in days if less than one month. Otherwise record in complete months or years.	YES.....1 NO.....0
42h	VILLAGE/CITY/TOWN _____ TALUK _____ DISTRICT _____ STATE _____	DAYS..... MONTHS..... YEARS..... Record in days if less than one month. Otherwise record in complete months or years.	YES.....1 NO.....0

**SECTION V: PATTERNS AND DETERMINANTS OF MOBILITY
(MIGRANT AND MOBILE WOMEN)**

Now we will speak about the last TWO places that you have gone to for sex work in the past one year. You may find that some questions are sensitive in nature. I want to remind you that your answers will be kept confidential.
(INTERVIEWER: Begin with Most Recent Place, then ask about the Recent Place).

No.	QUESTIONS	MOST RECENT PLACE	RECENT PLACE
43	Village/Town/City : Taluk: District: State:	 	
		REFER TO NAME OF PLACE WHEN ASKING Q.44-Q.54	REFER TO NAME OF PLACE WHEN ASKING Q.44-Q.54
44	When was the first time you were there? Record in months if less than one year. Otherwise record in complete years. Record '00' in months if less than one month.	MONTHS..... YEARS..... DON'T KNOW.....88	MONTHS..... YEARS..... DON'T KNOW.....88
45	How old were you the first time you went to this place (use appropriate name) for sex work?	AGE IN COMPLETED YEARS..... DON'T KNOW.....88 NO RESPONSE.....99	AGE IN COMPLETED YEARS..... DON'T KNOW.....88 NO RESPONSE.....99
46	The first time that you went to this place (use appropriate name), who made the decision for you to go there? Record one response.	OWN DECISION.....1 FAMILY DECIDED.....2 PIMP/BROKER DECIDED.....3 FRIENDS DECIDED.....4 CLIENT DECIDED.....5 LOVER DECIDED.....6 OTHER_____7 (SPECIFY)	OWN DECISION.....1 FAMILY DECIDED.....2 PIMP/BROKER DECIDED.....3 FRIENDS DECIDED.....4 CLIENT DECIDED.....5 LOVER DECIDED.....6 OTHER_____7 (SPECIFY)

**SECTION V: PATTERNS AND DETERMINANTS OF MOBILITY
(MIGRANT AND MOBILE WOMEN)**

No	QUESTIONS	MOST RECENT PLACE	RECENT PLACE
		REFER TO NAME OF PLACE WHEN ASKING Q.44-Q.54	REFER TO NAME OF PLACE WHEN ASKING Q.44-Q.54
47	a. How often do you go to this place (use appropriate name) for sex work? Record in <u>one</u> category only. If none of the above is applicable, then ask: b. How many times did you go in the past 10 years?	No. OF TIMES/WEEK..... No. OF TIMES/MONTH..... No. OF TIMES/YEAR..... No. OF TIMES/10 YEARS.....	No. OF TIMES/WEEK..... No. OF TIMES/MONTH..... No. OF TIMES/YEAR..... No. OF TIMES/10 YEARS.....
48	On average, how long do you stay each time you go to this place (use appropriate name) for sex work? Record in <u>one</u> category only.	HOURS..... DAYS..... MONTHS..... YEARS.....	HOURS..... DAYS..... MONTHS..... YEARS.....
49	Why do you go to this place (use appropriate name) for sex work? Probe and record all the responses mentioned.	MAINTAIN ANONYMITY.....A MORE MONEY.....B MORE CLIENTS.....C LESS POLICE HARASSMENT.....D FAMILY REASON.....E FAMILIAR WITH THIS PLACE.....F OTHER _____ G (SPECIFY)	MAINTAIN ANONYMITY.....A MORE MONEY.....B MORE CLIENTS.....C LESS POLICE HARASSMENT.....D FAMILY REASON.....E FAMILIAR WITH THIS PLACE.....F OTHER _____ G (SPECIFY)

**SECTION V: PATTERNS AND DETERMINANTS OF MOBILITY
(MIGRANT AND MOBILE WOMEN)**

No	QUESTIONS	MOST RECENT PLACE	RECENT PLACE
		REFER TO NAME OF PLACE WHEN ASKING Q.44-Q.54	REFER TO NAME OF PLACE WHEN ASKING Q.44-Q.54
50	Usually, who makes the decision for you to go to this place (use appropriate name) for sex work? Record one response.	OWN DECISION.....1 FAMILY DECIDES.....2 PIMP/BROKER DECIDES.....3 FRIENDS DECIDE.....4 CLIENT DECIDES.....5 LOVER DECIDES.....6 OTHER _____ 7 (SPECIFY)	OWN DECISION.....1 FAMILY DECIDES.....2 PIMP/BROKER DECIDES.....3 FRIENDS DECIDE.....4 CLIENT DECIDES.....5 LOVER DECIDES.....6 OTHER _____ 7 (SPECIFY)
51	Where do you normally stay when you go there? Record one response.	WITH FRIEND.....1 WITH RELATIVE.....2 BROTHEL/GHARWALI.....3 LODGE.....4 DON'T STAY.....77 OTHER _____ 5 (SPECIFY)	WITH FRIEND.....1 WITH RELATIVE.....2 BROTHEL/GHARWALI.....3 LODGE.....4 DON'T STAY.....77 OTHER _____ 5 (SPECIFY)
52	During what time of the year do you go to this place (use appropriate name) for sex work?	ANY TIME OF THE YEAR.....1 SK → Q53 FESTIVAL.....2 LIST: _____ 2A _____ 2B _____ 2C SPECIFIC MONTHS.....3 LIST: _____ 3A _____ 3B _____ 3C OTHER _____ 4 (SPECIFY)	ANY TIME OF THE YEAR.....1 SK → Q53 FESTIVAL.....2 LIST: _____ 2A _____ 2B _____ 2C SPECIFIC MONTHS.....3 LIST: _____ 3A _____ 3B _____ 3C OTHER _____ 4 (SPECIFY)

**SECTION V: PATTERNS AND DETERMINANTS OF MOBILITY
(MIGRANT AND MOBILE WOMEN)**

No.	QUESTIONS	MOST RECENT PLACE	RECENT PLACE
		REFER TO NAME OF PLACE WHEN ASKING Q.44-Q.54	REFER TO NAME OF PLACE WHEN ASKING Q.44-Q.54
53	Why do you go during that time? Record one response.	MORE CLIENTS.....1 MORE MONEY.....2 PIMP/BROKER DECIDES.....3 OTHER_____4 (SPECIFY) DON'T KNOW.....88	MORE CLIENTS.....1 MORE Y.....2 PIMP/BROKER DECIDES.....3 OTHER_____4 (SPECIFY) DON'T KNOW.....88
54a	When was the <u>last</u> time you visited this place (use appropriate name)? Record in days if less than one month. Record in months if less than one year. Otherwise record in complete years.	DAYS..... MONTHS..... YEARS.....	DAYS..... MONTHS..... YEARS.....
54b	How long did you stay on your <u>last</u> visit? Record in hours if less than 1 day. Record in days if less than one month. Record in months if less than one year. Otherwise record in complete years.	HOURS..... DAYS..... MONTHS..... YEARS.....	HOURS..... DAYS..... MONTHS..... YEARS.....

SECTION VI: BEHAVIOUR, RISK AND VULNERABILITY
(IN PLACE OF RESIDENCE)

No.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
55	Village/Town/City: Taluk: District: State:	 	
56a	Do you do sex work in this/your village (locale mentioned in either Q1 or Q2; that recorded in Q55)?	YES.....1 NO.....0 NO RESPONSE.....99	Q57
56b	Do you have a NON-PAYING PARTNER in this/your village (locale mentioned in either Q1 or Q2; that recorded in Q55)?	YES.....1 NO.....0 NO RESPONSE.....99	Q79 } SEC VII

Now we will speak in detail about sex work in your village (local mentioned in either Q1 or Q2; that recorded in Q55). The questions will be sensitive in nature and I will be asking about different client types, where you get (solicit) them and where you have sex with (entertain) them. I want to remind you again that your answers will remain confidential.

57	Where do you get (solicit) clients? Do not read responses. Record all mentioned.	MY HOUSE.....A RENTED ROOM.....B LODGE.....C DHABA.....D BROTHEL.....E BAR/NIGHT CLUB.....F VEHICLE.....G PARK.....H STREET.....I CINEMA HALLS.....J BUS STANDS.....K RAILWAY STATION.....L SOMEONE ELSE'S HOUSE.....M HIGHWAY.....N THROUGH PHONE.....O OTHER _____ P (SPECIFY)	
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**SECTION VI: BEHAVIOUR, RISK AND VULNERABILITY
(IN PLACE OF RESIDENCE)**

No.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
58	Where do you <u>mainly</u> get (solicit) your clients? Do not read responses. Record one response.	MY HOUSE.....1 RENTED ROOM.....2 LODGE.....3 DHABA.....4 BROTHEL.....5 BAR/NIGHT CLUB.....6 VEHICLE.....7 PARK.....8 STREET.....9 CINEMA HALLS.....10 BUS STANDS.....11 RAILWAY STATION.....12 SOMEONE ELSE'S HOUSE.....13 HIGHWAY.....14 THROUGH PHONE.....15 OTHER _____ 16 (SPECIFY)	
59	How do you <u>mostly</u> get (solicit) your clients? Do not read responses. Record one response.	INDEPENDENTLY.....1 BROKERS AND PIMPS.....2 MADAMS.....3 FRIENDS.....4 HUSBAND/LOVER.....5 THROUGH CLIENTS.....6 CLIENTS COME ON OWN.....7 OTHER _____ 8 (SPECIFY)	

SECTION VI: BEHAVIOUR, RISK AND VULNERABILITY
(IN PLACE OF RESIDENCE)

No.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
60	Where do you have sex (entertain)? Do not read responses. Record all mentioned.	MY HOUSE.....A RENTED ROOM.....B LODGE.....C DHABA.....D BROTHEL.....E BAR/NIGHT CLUB.....F VEHICLE.....G PARK.....H STREET.....I CINEMA HALLS.....J BUS STANDS.....K RAILWAY STATION.....L SOMEONE ELSE'S HOUSE.....M HIGHWAY.....N OTHER_____O (SPECIFY)	
61	Where do you <u>mainly</u> have sex (entertain)? Do not read responses. Record one response.	MY HOUSE.....1 RENTED ROOM.....2 LODGE.....3 DHABA.....4 BROTHEL.....5 BAR/NIGHT CLUB.....6 VEHICLE.....7 PARK.....8 STREET.....9 CINEMA HALLS.....10 BUS STANDS.....11 RAILWAY STATION.....12 SOMEONE ELSE'S HOUSE.....13 HIGHWAY.....14 OTHER_____15 (SPECIFY)	

**SECTION VI: BEHAVIOUR, RISK AND VULNERABILITY
(IN PLACE OF RESIDENCE)**

No.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
62	On average, how many clients do you have sex with (entertain) per day?	NUMBER OF CLIENTS/DAY..... NO RESPONSE.....99	
63	On average, how many sexual acts per day involve penetrative sex?	RECORD NUMBER..... <i>If '00', Skip to Q66</i> NO RESPONSE.....99 →	66
64	Of the penetrative sexual acts mentioned in Q63, how many encounters involve vaginal intercourse?	RECORD NUMBER..... NO RESPONSE.....99	
65	Of the penetrative sexual acts mentioned in Q63, how many encounters involve anal intercourse?	RECORD NUMBER..... NO RESPONSE.....99	
66	Who do you have sex with (entertain)? Read responses. Record all mentioned.	PAYING & NEW/OCCASIONAL CLIENT.....A PAYING & REGULAR CLIENT.....B NON-PAYING PARTNER.....C OTHER _____ D (SPECIFY)	
Now we will speak in detail about the penetrative sexual acts with different client/partner types. It may be repetitive to you to talk about this, but I will explain to you how the questions differ from each other. The questions will be sensitive in nature. I want to remind you again that your answers will remain confidential.			
67	During penetrative sexual acts with PAYING & NEW/OCCASIONAL CLIENTS , how often are condoms used? (EVERY TIME=100%, MOST OF THE TIME=99-50%, SOME OF THE TIME=49-1%), NOT USED=0%)	EVERY TIME.....1 MOST OF THE TIME.....2 SOME OF THE TIME.....3 NOT USED.....4 CLIENT TYPE N/A.....77 NO RESPONSE.....99	} Q69 } Q73

SECTION VI: BEHAVIOUR, RISK AND VULNERABILITY
(IN PLACE OF RESIDENCE)

No.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
68	Why do you use condoms every time with PAYING & NEW/OCCASIONAL CLIENTS ? Do not read responses. Record one response.	AFRAID OF HIV/AIDS.....1 TO PREVENT STI/STD.....2 TO AVOID PREGNANCY.....3 DON'T TRUST HIM/THEM.....4 OTHER.....5 (SPECIFY)	Q71
69	What are the reasons you do not regularly use condoms with PAYING & NEW/OCCASIONAL CLIENTS ? Do not read responses. Record all mentioned.	I TRUST THEM.....A THEY REFUSE.....B THEY AREN'T INFECTED.....C DID NOT HAVE CONDOMS.....D WANT TO GET PREGNANT.....E AFRAID OF CLIENT'S VIOLENCE.....F EMBARRASSED TO USE.....G DRUNK OR TAKEN DRUGS.....H DON'T LIKE IT.....I MORE MONEY.....J OTHER.....K DON'T KNOW.....88	
70	Can you give me a <u>main</u> reason for not regularly using condoms with PAYING & NEW/OCCASIONAL CLIENTS ? Do not read responses. Record one response.	I TRUST THEM.....1 THEY REFUSE.....2 THEY AREN'T INFECTED.....3 DID NOT HAVE CONDOMS.....4 WANT TO GET PREGNANT.....5 AFRAID OF CLIENT'S VIOLENCE.....6 EMBARRASSED TO USE.....7 DRUNK OR TAKEN DRUGS.....8 DON'T LIKE IT.....9 MORE MONEY.....10 OTHER.....11 DON'T KNOW.....88	Q71
71	Has there been a time when you have wanted to use a condom during sexual intercourse with a PAYING & NEW/OCCASIONAL CLIENT but you did not?	YES.....1 NO.....0 NEVER USE WITH THIS CLIENT TYPE.....77 DON'T KNOW.....88 NO RESPONSE.....99	Q73
72	What was the <u>main</u> reason for not using a condom? Do not read responses. Record one response.	CLIENT DID NOT WANT TO USE.....1 DID NOT HAVE A CONDOM.....2 CONDOM BROKE.....3 OTHER.....4 (SPECIFY)	

**SECTION VI: BEHAVIOUR, RISK AND VULNERABILITY
(IN PLACE OF RESIDENCE)**

No.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
73	During penetrative sexual acts with PAYING & REGULAR CLIENTS , how often are condoms used? (EVERY TIME=100%, MOST OF THE TIME=99-50%, SOME OF THE TIME=49-1%), NOT USED=0%)	EVERY TIME.....1 MOST OF THE TIME.....2 SOME OF THE TIME.....3 NOT USED.....4 CLIENT TYPE N/A.....77 NO RESPONSE.....99	Q75 Q79
74	Why do you use condoms every time with PAYING & REGULAR CLIENTS ? Do not read responses. Record one response.	AFRAID OF HIV/AIDS.....1 TO PREVENT STI/STD.....2 TO AVOID PREGNANCY.....3 DON'T TRUST HIM/THEM.....4 OTHER.....5 (SPECIFY)	Q77
75	What are the reasons you do not regularly use condoms with PAYING & REGULAR CLIENTS ? Do not read responses. Record all mentioned.	I TRUST THEM.....A THEY REFUSE.....B THEY AREN'T INFECTED.....C DID NOT HAVE CONDOMS.....D WANT TO GET PREGNANT.....E AFRAID OF CLIENT'S VIOLENCE.....F EMBARRASSED TO USE.....G DRUNK OR TAKEN DRUGS.....H DON'T LIKE IT.....I MORE MONEY.....J OTHER.....K DON'T KNOW.....88	Q77
76	Can you give me a <u>main</u> reason for not regularly using condoms with PAYING & REGULAR CLIENTS ? Do not read responses. Record one response.	I TRUST THEM.....1 THEY REFUSE.....2 THEY AREN'T INFECTED.....3 DID NOT HAVE CONDOMS.....4 WANT TO GET PREGNANT.....5 AFRAID OF CLIENT'S VIOLENCE.....6 EMBARRASSED TO USE.....7 DRUNK OR TAKEN DRUGS.....8 DON'T LIKE IT.....9 MORE MONEY.....10 OTHER.....11 DON'T KNOW.....88	
77	Has there been a time when you have wanted to use a condom during sexual intercourse with a PAYING & REGULAR CLIENT but you did not?	YES.....1 NO.....0 NEVER USE WITH THIS CLIENT TYPE.....77 DON'T KNOW.....88 NO RESPONSE.....99	Q79
78	What was the <u>main</u> reason for not using a condom? Do not read responses. Record one response.	CLIENT DID NOT WANT TO USE.....1 DID NOT HAVE A CONDOM.....2 CONDOM BROKE.....3 OTHER.....4 (SPECIFY)	

**SECTION VI: BEHAVIOUR, RISK AND VULNERABILITY
(IN PLACE OF RESIDENCE)**

No.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
79	During penetrative sexual acts with NON-PAYING PARTNERS, how often are condoms used? (EVERY TIME=100%, MOST OF THE TIME=99-50%, SOME OF THE TIME=49-1%), NOT USED=0%)	EVERY TIME.....1 MOST OF THE TIME.....2 SOME OF THE TIME.....3 NOT USED.....4 PARTNER TYPE N/A.....77 NO RESPONSE.....99	Q81 Q85
80	Why do you use condoms every time with NON-PAYING PARTNERS? Do not read responses. Record one response.	AFRAID OF HIV/AIDS.....1 TO PREVENT STI/STD.....2 TO AVOID PREGNANCY.....3 DON'T TRUST HIM/THEM.....4 OTHER.....5 (SPECIFY)	Q83
81	What are the reasons you do not regularly use condoms with NON-PAYING PARTNERS? Do not read responses. Record all mentioned.	I TRUST THEM.....A THEY REFUSE.....B THEY AREN'T INFECTED.....C DID NOT HAVE CONDOMS.....D WANT TO GET PREGNANT.....E AFRAID OF PARTNER'S VIOLENCE.....F EMBARRASSED TO USE.....G DRUNK OR TAKEN DRUGS.....H DON'T LIKE IT.....I MORE MONEY.....J OTHER.....K DON'T KNOW.....88	Q83
82	Can you give me a <u>main</u> reason for not regularly using condoms with NON-PAYING PARTNERS? Do not read responses. Record one response.	I TRUST THEM.....1 THEY REFUSE.....2 THEY AREN'T INFECTED.....3 DID NOT HAVE CONDOMS.....4 WANT TO GET PREGNANT.....5 AFRAID OF PARTNER'S VIOLENCE.....6 EMBARRASSED TO USE.....7 DRUNK OR TAKEN DRUGS.....8 DON'T LIKE IT.....9 MORE MONEY.....10 OTHER.....11 DON'T KNOW.....88	
83	Has there been a time when you have wanted to use a condom during sexual intercourse with a NON-PAYING PARTNER but you did not?	YES.....1 NO.....0 NEVER USE CONDOMS WITH NON-PAYING PARTNERS.77 DON'T KNOW.....88 NO RESPONSE.....99	IF Q56a IS 'NO'/'N R'SK TO SEC VII OTHERWISE TO Q85

**SECTION VI: BEHAVIOUR, RISK AND VULNERABILITY
(IN PLACE OF RESIDENCE)**

No.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
84	What was the <u>main</u> reason for not using a condom? Do not read responses. Record one response.	PARTNER DID NOT WANT TO USE.....1 DID NOT HAVE A CONDOM.....2 CONDOM BROKE.....3 OTHER.....4 (SPECIFY)	IF Q56a IS 'NO' / 'NR' SK TO SEC VII OTHERWISE GO TO Q85
85	Have you ever had sex in a group? By that I mean vaginal/anal/oral sex with more than one man at the same time.	YES.....1 NO.....0 NO RESPONSE.....99	Q87
86	Last time you had sexual intercourse with more than one man at the same time, how many men were there?	NUMBER OF MEN..... DON'T KNOW.....88 NO REPSONSE.....99	
87	Have you ever been forced to have sexual intercourse?	YES.....1 NO.....0 NO RESPONSE.....99	Q89
88	Who forced you to have sex against your will? Do not read responses. Record all mentioned.	PIMP.....A CLIENT.....B REGULAR PARNTER.....C POLICE.....D HUSBAND.....E OTHER.....F (SPECIFY) DON'T KNOW.....88 NO RESPONSE.....99	
89	Have you been physically abused by your client?	YES.....1 NO.....0 NO RESPONSE.....99	
90	Have you faced harassmtent or physical abuse by the police?	YES.....1 NO.....0 NO RESPONSE.....99	
91	Have you ever been arrested?	YES.....1 NO.....0 NO RESPONSE.....99	**
92	How many times have you been arrested?	RECORD.....	

****CHECK Q41, IF THE PARTICIPANT HAS BEEN CODED 'LOCAL' THEN SKIP TO SECTION VIII. IF THE PARTICIPANT IS CODED AS 'MIGRANT' OR 'MOBILE', THEN CONTINUE WITH SECTION VII.**

SECTION VII: BEHAVIOUR, RISK AND VULNERABILITY (MIGRANT AND MOBILE WOMEN)

Now we will speak in detail about the last TWO places that you have gone to for sex work in the past one year. The questions will be sensitive in nature and I will be asking about different client types, where you get (solicit) them and where you have sex with (entertain) them. I want to remind you again that your answers will remain confidential.

(INTERVIEWER: Begin with Most Recent Place and then ask about Recent Place.)

No.	QUESTIONS	MOST RECENT PLACE	RECENT PLACE
93	Village/Town/City: Taluk: District: State:	 	
		REFER TO NAME OF PLACE WHEN ASKING Q.94-Q.129	REFER TO NAME OF PLACE WHEN ASKING Q.94-Q.129
94	In the MOST RECENT and RECENT PLACE (use appropriate name), where do you get (solicit) clients? Do not read responses. Record all mentioned.	MY HOUSE.....A RENTED ROOM.....B LODGE.....C DHABA.....D BROTHEL.....E BAR/NIGHT CLUB.....F VEHICLE.....G PARK.....H STREET.....I CINEMA HALLS.....J BUS STANDS.....K RAILWAY STATION.....L SOMEONE ELSE'S HOUSE.....M HIGHWAY.....N THROUGH PHONE.....O OTHER _____ P (SPECIFY)	MY HOUSE.....A RENTED ROOM.....B LODGE.....C DHABA.....D BROTHEL.....E BAR/NIGHT CLUB.....F VEHICLE.....G PARK.....H STREET.....I CINEMA HALLS.....J BUS STANDS.....K RAILWAY STATION.....L SOMEONE ELSE'S HOUSE.....M HIGHWAY.....N THROUGH PHONE.....O OTHER _____ P (SPECIFY)

**SECTION VII: BEHAVIOUR, RISK AND VULNERABILITY
(MIGRANT AND MOBILE WOMEN)**

No.	QUESTIONS	MOST RECENT PLACE	RECENT PLACE
		REFER TO NAME OF PLACE WHEN ASKING Q.94-Q.129	REFER TO NAME OF PLACE WHEN ASKING Q.94-Q.129
95	Where do you <u>mainly</u> get (solicit) clients, in the MOST RECENT and RECENT PLACE (use appropriate name) ? Do not read responses. Record one response.	MY HOUSE.....1 RENTED ROOM.....2 LODGE.....3 DHABA.....4 BROTHEL.....5 BAR/NIGHT CLUB.....6 VEHICLE.....7 PARK.....8 STREET.....9 CINEMA HALLS.....10 BUS STANDS.....11 RAILWAY STATION.....12 SOMEONE ELSE'S HOUSE.....13 HIGHWAY.....14 THROUGH PHONE.....15 OTHER_____16 (SPECIFY)	MY HOUSE.....1 RENTED ROOM.....2 LODGE.....3 DHABA.....4 BROTHEL.....5 BAR/NIGHT CLUB.....6 VEHICLE.....7 PARK.....8 STREET.....9 CINEMA HALLS.....10 BUS STANDS.....11 RAILWAY STATION.....12 SOMEONE ELSE'S HOUSE.....13 HIGHWAY.....14 THROUGH PHONE.....15 OTHER_____16 (SPECIFY)
96	How do you <u>mostly</u> get (solicit) your clients, in the MOST RECENT and RECENT PLACE (use appropriate name) ? Do not read responses. Record one response.	INDEPENDENTLY.....1 BROKERS AND PIMPS.....2 MADAMS.....3 FRIENDS.....4 HUSBAND/LOVER.....5 THROUGH CLIENTS.....6 CLIENTS COME ON OWN.....7 OTHER_____8 (SPECIFY)	INDEPENDENTLY.....1 BROKERS AND PIMPS.....2 MADAMS.....3 FRIENDS.....4 HUSBAND/LOVER.....5 THROUGH CLIENTS.....6 CLIENTS COME ON OWN.....7 OTHER_____8 (SPECIFY)

SECTION VII: BEHAVIOUR, RISK AND VULNERABILITY
(MIGRANT AND MOBILE WOMEN)

No.	QUESTIONS	MOST RECENT PLACE	RECENT PLACE
		REFER TO NAME OF PLACE WHEN ASKING Q.94-Q.129	REFER TO NAME OF PLACE WHEN ASKING Q.94-Q.129
97	Where do you have sex (entertain), in the MOST RECENT and RECENT PLACE (use appropriate name)? Do not read responses. Record all mentioned.	MY HOUSE.....A RENTED ROOM.....B LODGE.....C DHABA.....D BROTHEL.....E BAR/NIGHT CLUB.....F VEHICLE.....G PARK.....H STREET.....I CINEMA HALLS.....J BUS STANDS.....K RAILWAY STATION.....L SOMEONE ELSE'S HOUSE.....M HIGHWAY.....N OTHER.....O (SPECIFY)	MY HOUSE.....A RENTED ROOM.....B LODGE.....C DHABA.....D BROTHEL.....E BAR/NIGHT CLUB.....F VEHICLE.....G PARK.....H STREET.....I CINEMA HALLS.....J BUS STANDS.....K RAILWAY STATION.....L SOMEONE ELSE'S HOUSE.....M HIGHWAY.....N OTHER.....O (SPECIFY)
98	Where do you mainly have sex (entertain), in the MOST RECENT and RECENT PLACE (use appropriate name)? Do not read responses. Record one response.	MY HOUSE.....1 RENTED ROOM.....2 LODGE.....3 DHABA.....4 BROTHEL.....5 BAR/NIGHT CLUB.....6 VEHICLE.....7 PARK.....8 STREET.....9 CINEMA HALLS.....10 BUS STANDS.....11 RAILWAY STATION.....12 SOMEONE ELSE'S HOUSE.....13 HIGHWAY.....14 OTHER.....15 (SPECIFY)	MY HOUSE.....1 RENTED ROOM.....2 LODGE.....3 DHABA.....4 BROTHEL.....5 BAR/NIGHT CLUB.....6 VEHICLE.....7 PARK.....8 STREET.....9 CINEMA HALLS.....10 BUS STANDS.....11 RAILWAY STATION.....12 SOMEONE ELSE'S HOUSE.....13 HIGHWAY.....14 OTHER.....15 (SPECIFY)
99	On average, how many clients do you have sex with (entertain) per day, in the MOST RECENT and RECENT PLACE (use appropriate name)?	NUMBER OF CLIENTS/DAY..... NO RESPONSE.....99	NUMBER OF CLIENTS/DAY..... NO RESPONSE.....99

SECTION VII: BEHAVIOUR, RISK AND VULNERABILITY
(MIGRANT AND MOBILE WOMEN)

No.	QUESTIONS	MOST RECENT PLACE	RECENT PLACE
		REFER TO NAME OF PLACE WHEN ASKING Q.94-Q.129	REFER TO NAME OF PLACE WHEN ASKING Q.94-Q.129
100	On average, how many sexual acts per day involve penetrative sex, in the MOST RECENT and RECENT PLACE (use appropriate name)?	RECORD NUMBER..... NO RESPONSE.....99 <i>If '00' or 'No Response', Skip to Q103</i>	RECORD NUMBER..... NO RESPONSE.....99 <i>If '00' or 'No Response', Skip to Q103</i>
101	Of the penetrative sexual acts mentioned in Q100, how many encounters involve vaginal intercourse?	RECORD NUMBER..... NO RESPONSE.....99	RECORD NUMBER..... NO RESPONSE.....99
102	Of the penetrative sexual acts mentioned in Q100, how many encounters involve anal intercourse?	RECORD NUMBER..... NO RESPONSE.....99	RECORD NUMBER..... NO RESPONSE.....99
103	Who do you have sex with (entertain) in the MOST RECENT and RECENT PLACE (use appropriate name of place)? Read responses. Record all mentioned.	PAYING & NEW/OCCASIONAL CLIENT.....A PAYING & REGULAR CLIENT...B NON-PAYING PARTNER.....C OTHER_____D (SPECIFY)	PAYING & NEW/OCCASIONAL CLIENT.....A PAYING & REGULAR CLIENT...B NON-PAYING PARTNER.....C OTHER_____D (SPECIFY)

SECTION VII: BEHAVIOUR, RISK AND VULNERABILITY
(MIGRANT AND MOBILE WOMEN)

Now we will speak in detail about your penetrative sexual acts with different client/partner types in the last TWO places you have gone to for sex work in the past one year. It may be repetitive to you to talk about this, but I will explain to you how the questions differ from each other. The questions will be sensitive in nature. I want to remind you again that your answers will remain confidential.
 (INTERVIEWER: Begin with Most Recent Place and then ask about Recent Place.)

No.	QUESTIONS	MOST RECENT PLACE	RECENT PLACE
		REFER TO NAME OF PLACE WHEN ASKING Q.94-Q.129	REFER TO NAME OF PLACE WHEN ASKING Q.94-Q.129
104	During penetrative sexual acts with PAYING & NEW/OCCASIONAL CLIENTS , how often are condoms used? (EVERY TIME=100%, MOST OF THE TIME=99-50%, SOME OF THE TIME=49-1%, NOT USED=0%)	EVERY TIME.....1 MOST OF THE TIME....2 } SKIP SOME OF THE TIME....3 } TO NOT USED.....4 } Q106 CLIENT TYPE N/A...77 } SK TO NO RESPONSE.....99 } Q110	EVERY TIME.....1 MOST OF THE TIME....2 } SKIP SOME OF THE TIME....3 } TO NOT USED.....4 } Q106 CLIENT TYPE N/A...77 } SK TO NO RESPONSE.....99 } Q110
105	Why do you use condoms every time with PAYING & NEW/OCCASIONAL CLIENTS ? Do not read responses. Record one response.	AFRAID OF HIV/AIDS...1 TO PREVENT STI/STD.....2 TO AVOID PREGNANCY.....3 } SKIP TO Q108 DON'T TRUST HIM/THEM.....4 OTHER _____ 5 (SPECIFY)	AFRAID OF HIV/AIDS...1 TO PREVENT STI/STD.....2 TO AVOID PREGNANCY.....3 } SKIP TO Q108 DON'T TRUST HIM/THEM.....4 OTHER _____ 5 (SPECIFY)
106	What are the reasons you do not regularly use condoms with PAYING & NEW/OCCASIONAL CLIENTS ? Do not read responses. Record all mentioned.	I TRUST THEM.....A THEY REFUSE.....B THEY AREN'T INFECTED.....C DIDN'T HAVE CONDOMS.....D WANT TO GET PREGNANT.....E AFRAID OF CLIENT'S VIOLENCE.....F EMBARRASSED TO USE.....G DRUNK OR TAKEN DRUGS.....H DON'T LIKE IT.....I MORE MONEY.....J OTHER _____ K DON'T KNOW.....88 **If 'Don't Know', Skip to Q108	I TRUST THEM.....A THEY REFUSE.....B THEY AREN'T INFECTED.....C DIDN'T HAVE CONDOMS.....D WANT TO GET PREGNANT.....E AFRAID OF CLIENT'S VIOLENCE.....F EMBARRASSED TO USE.....G DRUNK OR TAKEN DRUGS.....H DON'T LIKE IT.....I MORE MONEY.....J OTHER _____ K DON'T KNOW.....88 **If 'Don't Know', Skip to Q108

**SECTION VII: BEHAVIOUR, RISK AND VULNERABILITY
(MIGRANT AND MOBILE WOMEN)**

No.	QUESTIONS	MOST RECENT PLACE	RECENT PLACE
		REFER TO NAME OF PLACE WHEN ASKING Q.94-Q.129	REFER TO NAME OF PLACE WHEN ASKING Q.94-Q.129
107	Can you give me a main reason for not regularly using condoms with PAYING & NEW/OCCASIONAL CLIENTS ? Do not read responses. Record one response.	I TRUST THEM.....1 THEY REFUSE.....2 THEY AREN'T INFECTED.....3 DIDN'T HAVE CONDOMS.....4 WANT TO GET PREGNANT.....5 AFRAID OF CLIENT'S VIOLENCE.....6 EMBARRASSED TO USE.....7 DRUNK OR TAKEN DRUGS.....8 DON'T LIKE IT.....9 MORE MONEY.....10 OTHER.....11 DON'T KNOW.....88	I TRUST THEM.....1 THEY REFUSE.....2 THEY AREN'T INFECTED.....3 DIDN'T HAVE CONDOMS.....4 WANT TO GET PREGNANT.....5 AFRAID OF CLIENT'S VIOLENCE.....6 EMBARRASSED TO USE.....7 DRUNK OR TAKEN DRUGS.....8 DON'T LIKE IT.....9 MORE MONEY.....10 OTHER.....11 DON'T KNOW.....88
108	Has there been a time when you have wanted to use a condom during sexual intercourse with a PAYING & NEW/OCCASIONAL CLIENT but you did not?	YES.....1 NO.....0 NEVER USE CONDOMS WITH THIS CLIENT TYPE.....77 } SK DON'T KNOW.....88 TO NO RESPONSE.....99 Q110	YES.....1 NO.....0 NEVER USE CONDOMS WITH THIS CLIENT TYPE.....77 } SK DON'T KNOW.....88 TO NO RESPONSE.....99 Q110
109	What was the main reason for not using a condom? Do not read responses. Record one response.	CLIENT DID NOT WANT TO USE.....1 DID NOT HAVE A CONDOM.....2 CONDOM BROKE.....3 OTHER.....4 (SPECIFY)	CLIENT DID NOT WANT TO USE.....1 DID NOT HAVE A CONDOM.....2 CONDOM BROKE.....3 OTHER.....4 (SPECIFY)
110	During penetrative sexual acts with PAYING & REGULAR CLIENTS , how often are condoms used? (EVERY TIME=100%, MOST OF THE TIME=99-50%, SOME OF THE TIME=49-1%, NOT USED=0%)	EVERY TIME.....1 MOST OF THE TIME.....2 } SKIP SOME OF THE TIME.....3 TO NOT USED.....4 Q112 CLIENT TYPE N/A.....77 } SK TO NO RESPONSE.....99 Q116	EVERY TIME.....1 MOST OF THE TIME.....2 } SKIP SOME OF THE TIME.....3 TO NOT USED.....4 Q112 CLIENT TYPE N/A.....77 } SK TO NO RESPONSE.....99 Q116

**SECTION VII: BEHAVIOUR, RISK AND VULNERABILITY
(MIGRANT AND MOBILE WOMEN)**

No.	QUESTIONS	MOST RECENT PLACE	RECENT PLACE
		REFER TO NAME OF PLACE WHEN ASKING Q.94-Q.129	REFER TO NAME OF PLACE WHEN ASKING Q.94-Q.129
111	Why do you use condoms every time with PAYING & REGULAR CLIENTS? Do not read responses. Record one response.	AFRAID OF HIV/AIDS...1 TO PREVENT STI/STD.....2 TO AVOID PREGNANCY.....3 Q114 DON'T TRUST HIM/THEM.....4 OTHER.....5 (SPECIFY) SKIP TO	AFRAID OF HIV/AIDS...1 TO PREVENT STI/STD.....2 TO AVOID PREGNANCY.....3 DON'T TRUST HIM/THEM.....4 OTHER.....5 (SPECIFY) SKIP TO Q114
112	What are the reasons you do not regularly use condoms with PAYING & REGULAR CLIENTS? Do not read responses. Record all mentioned.	I TRUST THEM.....A THEY REFUSE.....B THEY AREN'T INFECTED.....C DIDN'T HAVE CONDOMS.....D WANT TO GET PREGNANT.....E AFRAID OF CLIENT'S VIOLENCE.....F EMBARRASSED TO USE.....G DRUNK OR TAKEN DRUGS.....H DON'T LIKE IT.....I MORE MONEY.....J OTHER.....K DON'T KNOW.....88 **If 'Don't Know', Skip to Q114	I TRUST THEM.....A THEY REFUSE.....B THEY AREN'T INFECTED.....C DIDN'T HAVE CONDOMS.....D WANT TO GET PREGNANT.....E AFRAID OF CLIENT'S VIOLENCE.....F EMBARRASSED TO USE.....G DRUNK OR TAKEN DRUGS.....H DON'T LIKE IT.....I MORE MONEY.....J OTHER.....K DON'T KNOW.....88 **If 'Don't Know', Skip to Q114
113	Can you give me a <u>main</u> reason for not regularly using condoms with PAYING & REGULAR CLIENTS? Do not read responses. Record one response.	I TRUST THEM.....1 THEY REFUSE.....2 THEY AREN'T INFECTED.....3 DIDN'T HAVE CONDOMS.....4 WANT TO GET PREGNANT.....5 AFRAID OF CLIENT'S VIOLENCE.....6 EMBARRASSED TO USE.....7 DRUNK OR TAKEN DRUGS.....8 DON'T LIKE IT.....9 MORE MONEY.....10 OTHER.....11 DON'T KNOW.....88	I TRUST THEM.....1 THEY REFUSE.....2 THEY AREN'T INFECTED.....3 DIDN'T HAVE CONDOMS.....4 WANT TO GET PREGNANT.....5 AFRAID OF CLIENT'S VIOLENCE.....6 EMBARRASSED TO USE.....7 DRUNK OR TAKEN DRUGS.....8 DON'T LIKE IT.....9 MORE MONEY.....10 OTHER.....11 DON'T KNOW.....88
114	Has there been a time when you have wanted to use a condom during sexual intercourse with a PAYING & REGULAR CLIENT but you did not?	YES.....1 NO.....0 NEVER USE CONDOMS WITH THIS CLIENT TYPE.....77 DON'T KNOW.....88 NO RESPONSE.....99 SK TO Q116	YES.....1 NO.....0 NEVER USE CONDOMS WITH THIS CLIENT TYPE.....77 DON'T KNOW.....88 NO RESPONSE.....99 SK TO Q116

**SECTION VII: BEHAVIOUR, RISK AND VULNERABILITY
(MIGRANT AND MOBILE WOMEN)**

No.	QUESTIONS	MOST RECENT PLACE	RECENT PLACE
		REFER TO NAME OF PLACE WHEN ASKING Q.94-Q.129	REFER TO NAME OF PLACE WHEN ASKING Q.94-Q.129
115	What was the <u>main</u> reason for not using a condom? Do not read responses. Record one response.	CLIENT DID NOT WANT TO USE.....1 DID NOT HAVE A CONDOM.....2 CONDOM BROKE.....3 OTHER _____ 4 (SPECIFY)	CLIENT DID NOT WANT TO USE.....1 DID NOT HAVE A CONDOM.....2 CONDOM BROKE.....3 OTHER _____ 4 (SPECIFY)
116	During penetrative sexual acts with NON-PAYING PARTNERS , how often are condoms used? (EVERY TIME=100%, MOST OF THE TIME=99-50%, SOME OF THE TIME=49-1%, NOT USED=0%)	EVERY TIME.....1 MOST OF THE TIME....2 SOME OF THE TIME....3 NOT USED.....4 PARTNER TYPE N/A...77 NO RESPONSE.....99	EVERY TIME.....1 MOST OF THE TIME....2 SOME OF THE TIME....3 NOT USED.....4 PARTNER TYPE N/A...77 NO RESPONSE.....99
117	Why do you use condoms every time with NON-PAYING PARTNERS ? Do not read responses. Record one response.	AFRAID OF HIV/AIDS...1 TO PREVENT STI/STD.....2 TO AVOID PREGNANCY.....3 DON'T TRUST HIM/THEM.....4 OTHER _____ 5 (SPECIFY)	AFRAID OF HIV/AIDS...1 TO PREVENT STI/STD.....2 TO AVOID PREGNANCY.....3 DON'T TRUST HIM/THEM.....4 OTHER _____ 5 (SPECIFY)
118	What are the reasons you do not regularly use condoms with NON-PAYING PARTNERS ? Do not read responses. Record all mentioned.	I TRUST THEM.....A THEY REFUSE.....B THEY AREN'T INFECTED.....C DIDN'T HAVE CONDOMS.....D WANT TO GET PREGNANT.....E AFRAID OF PARTNER'S VIOLENCE.....F EMBARRASSED TO USE.....G DRUNK OR TAKEN DRUGS.....H DON'T LIKE IT.....I MORE MONEY.....J OTHER _____ K DON'T KNOW.....88 **If 'Don't Know', Skip to Q120	I TRUST THEM.....A THEY REFUSE.....B THEY AREN'T INFECTED.....C DIDN'T HAVE CONDOMS.....D WANT TO GET PREGNANT.....E AFRAID OF PARTNER'S VIOLENCE.....F EMBARRASSED TO USE.....G DRUNK OR TAKEN DRUGS.....H DON'T LIKE IT.....I MORE MONEY.....J OTHER _____ K DON'T KNOW.....88 **If 'Don't Know', Skip to Q120

**SECTION VII: BEHAVIOUR, RISK AND VULNERABILITY
(MIGRANT AND MOBILE WOMEN)**

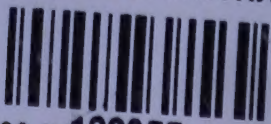
No.	QUESTIONS	MOST RECENT PLACE	RECENT PLACE
		REFER TO NAME OF PLACE WHEN ASKING Q.94-Q.129	REFER TO NAME OF PLACE WHEN ASKING Q.94-Q.129
119	Can you give me a <u>main</u> reason for not regularly using condoms with NON-PAYING PARTNERS ? Do not read responses. Record one response.	I TRUST THEM.....1 THEY REFUSE.....2 THEY AREN'T INFECTED.....3 DIDN'T HAVE CONDOMS.....4 WANT TO GET PREGNANT.....5 AFRAID OF PARTNER'S VIOLENCE.....6 EMBARRASSED TO USE.....7 DRUNK OR TAKEN DRUGS.....8 DON'T LIKE IT.....9 MORE MONEY.....10 OTHER.....11 DON'T KNOW.....88	I TRUST THEM.....1 THEY REFUSE.....2 THEY AREN'T INFECTED.....3 DIDN'T HAVE CONDOMS.....4 WANT TO GET PREGNANT.....5 AFRAID OF PARTNER'S VIOLENCE.....6 EMBARRASSED TO USE.....7 DRUNK OR TAKEN DRUGS.....8 DON'T LIKE IT.....9 MORE MONEY.....10 OTHER.....11 DON'T KNOW.....88
120	Has there been a time when you have wanted to use a condom during sexual intercourse with a NON-PAYING PARTNER but you did not?	YES.....1 NO.....0 NEVER USE CONDOMS WITH NON-PAYING PARTNERS.....77 DON'T KNOW.....88 NO RESPONSE.....99	YES.....1 NO.....0 NEVER USE CONDOMS WITH NON-PAYING PARTNERS.....77 DON'T KNOW.....88 NO RESPONSE.....99
121	What was the <u>main</u> reason for not using a condom? Do not read responses. Record one response.	PARTNER DID NOT WANT TO USE.....1 DID NOT HAVE A CONDOM.....2 CONDOM BROKE.....3 OTHER.....4 (SPECIFY)	PARTNER DID NOT WANT TO USE.....1 DID NOT HAVE A CONDOM.....2 CONDOM BROKE.....3 OTHER.....4 (SPECIFY)
122	Have you ever had sex in a group? By that I mean vaginal/anal/oral sex with more than one man at the same time.	YES.....1 NO.....0 NO RESPONSE.....99	YES.....1 NO.....0 NO RESPONSE.....99
123	Last time you had sexual intercourse with more than one man at the same time, how many men were there?	NUMBER OF MEN..... DON'T KNOW.....88 NO REPSONSE.....99	NUMBER OF MEN..... DON'T KNOW.....88 NO REPSONSE.....99
124	Have you ever been forced to have sexual intercourse?	YES.....1 NO.....0 NO RESPONSE.....99	YES.....1 NO.....0 NO RESPONSE.....99

SECTION VII: BEHAVIOUR, RISK AND VULNERABILITY
(MIGRANT AND MOBILE WOMEN)

No.	QUESTIONS	MOST RECENT PLACE	RECENT PLACE						
		REFER TO NAME OF PLACE WHEN ASKING Q.94-Q.129	REFER TO NAME OF PLACE WHEN ASKING Q.94-Q.129						
125	Who forced you to have sex against your will? Do not read responses. Record all mentioned.	PIMP.....A CLIENT.....B REGULAR PARNTER.....C POLICE.....D HUSBAND.....E OTHER.....F (SPECIFY) DON'T KNOW.....88 NO RESPONSE.....99	PIMP.....A CLIENT.....B REGULAR PARNTER.....C POLICE.....D HUSBAND.....E OTHER.....F (SPECIFY) DON'T KNOW.....88 NO RESPONSE.....99						
126	Have you been physically abused by your client?	YES.....1 NO.....0 NO RESPONSE.....99	YES.....1 NO.....0 NO RESPONSE.....99						
127	Have you faced harassment or physical abuse by the police?	YES.....1 NO.....0 NO RESPONSE.....99	YES.....1 NO.....0 NO RESPONSE.....99						
128	Have you ever been arrested?	YES.....1 NO.....0 NO RESPONSE.....99 If 'No' or 'No Response', Skip to Section VIII	YES.....1 NO.....0 NO RESPONSE.....99 If 'No' or 'No Response', Skip to Section VIII						
129	How many times have you been arrested?	RECORD..... <table><tr><td></td><td></td><td></td></tr></table>				RECORD..... <table><tr><td></td><td></td><td></td></tr></table>			

The interview ends here. Thank you very much for your time and for providing the information. I assure you again that the information you have given to us will remain completely anonymous.

AKSHARA GRANTHALAYA



ACC.NO. 132055

